SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Filing at a Glance

Company: QCA Health Plan, Inc.

Product Name: QCA Conversion Policy Eff August 2011	SERFF Tr Num: QUAC-127331254	State: Arkansas
TOI: H06 Health - Conversion	SERFF Status: Closed-Approved-Closed	State Tr Num: 49356
Sub-TOI: H06.000 Health - Conversion	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Rosalind Minor
	Authors: Jim Couch, Niki Thomas	Disposition Date: 07/28/2011
	Date Submitted: 07/20/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date: 08/01/2011

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 07/28/2011
	State Status Changed: 07/28/2011
Deemer Date:	Created By: Jim Couch
Submitted By: Jim Couch	Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

New Conversion policy, along with Amendment to existing Conversion policies in order to bring into compliance for PPACA and state mandated benefits to the extent applicable.

Company and Contact

Filing Contact Information

Jim Couch, VP of Compliance	jim.couch@qualchoice.com

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

12615 Chenal Parkway, Suite 300 501-228-7111 [Phone] 5118 [Ext]
Little Rock, AR 72211 501-707-6729 [FAX]

Filing Company Information

QCA Health Plan, Inc.	CoCode: 95448	State of Domicile: Arkansas
12615 Chenal Parkway, Suite 300	Group Code:	Company Type: Health Maintenance Organization
Little Rock, AR 72211	Group Name:	State ID Number:
(501) 228-7111 ext. [Phone]	FEIN Number: 71-0794605	

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	No
Fee Explanation:	2 Form Schedules, 1 Rate Summary, 1 Application, 2 Benefit Summaries @ $50 each.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QCA Health Plan, Inc.	$0.00	07/20/2011	

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/28/2011	07/28/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	07/28/2011	07/28/2011	Jim Couch	07/28/2011	07/28/2011
Pending Industry Response	Rosalind Minor	07/28/2011	07/28/2011	Jim Couch	07/28/2011	07/28/2011
Pending Industry Response	Rosalind Minor	07/21/2011	07/21/2011			

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
QCA Conversion Policy 8/11	Note To Reviewer	Jim Couch	07/24/2011	07/24/2011
Redlined compare of current EOC with Conversion EOC	Note To Reviewer	Jim Couch	07/20/2011	07/20/2011

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 07/28/2011
Implementation Date: 08/01/2011
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed by Actuary
Comment:
This submission is being approved on this date with the exception of Form QCA Conversion (8-11). As you requested, this form is being withdrawn.

We have approved a 9.9% rate increase on your submission. The approval is subject to the following conditions:

1. Rate increases will not be given prior to the first annual anniversary date of any policy.
2. After the first annual anniversary date of any policy, increases will not be given more frequently than once in a twelve (12) month period.
3. All increases in rates, other than a change in age or an individual moving to another geographical area, must be submitted to our Department for approval.
4. Your company agrees to provide notice to potential conversion applicants that they could be eligible for the CHIP Program , along with providing a phone number and the website for CHIP.

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Company Name:	**Overall % Indicated Change:**	**Overall % Rate Impact:**	**Written Premium Change for this Program:**	**# of Policy Holders Affected for this Program:**	**Written Premium for this Program:**	**Maximum % Change (where required):**	**Minimum % Change (where required):**
QCA Health Plan, Inc.	%	%	$		$	%	%
	Percent Change Approved:						
	Minimum:	9.9%	**Maximum:**	9.9%	**Weighted Average:**		9.9%

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document *(revised)*	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form *(revised)*	Conversion Evidence of Coverage Certificate	Withdrawn	No
Form	Conversion Evidence of Coverage Certificate	Withdrawn	No
Form *(revised)*	Amendment to Conversion Evidence of Coverage	Approved-Closed	Yes
Form	Amendment to Conversion Evidence of Coverage	Replaced	Yes
Form	Amendment to Conversion Evidence of Coverage	Replaced	Yes
Rate *(revised)*	QCA Conversion Rate Summary Eff Aug 2011	Approved-Closed	Yes
Rate	QCA Conversion Rate Summary Eff Aug 2011	Replaced	Yes

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/28/2011
Submitted Date	07/28/2011
Respond By Date	

Dear Jim Couch,

This will acknowledge receipt of the captioned filing.

Objection 1

- Amendment to Conversion Evidence of Coverage, QCA HMO (01-01-05) Amended Conversion (Form)

Comment:

Item 3.19, Maternity Services, has not been changed. It reads the same as the replaced amendment. The statement is not in compliance with ACA 23-86-115 (b)(2) which reads...."The conversion policy shall not exclude coverage for pregnancy or other illnesss or injury on the grounds of a preexisting condition, provided that the combination of time served under the group and the conversion policy equals or exceeds any waiting periods under the group policy or contract. Moreover, the conversion policy shall include benefits for maternity coverage for any pregnancies in existence at the time of conversion.....".

Objection 2

- Conversion Evidence of Coverage Certificate, QCA Conversion (8-11) (Form)

Comment:

As discussed in our telephone conversation this morning, you were going to attempt to remove this attachment. It is still showing on the screen. If you would please respond to this objection letter and request that I withdraw the form, I will mark it withdraw upon my final disposition.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/28/2011
Submitted Date	07/28/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: Please see the revised amendment with the changes requested to Sec. 3.19.

Related Objection 1

Applies To:

- Amendment to Conversion Evidence of Coverage, QCA HMO (01-01-05) Amended Conversion (Form)

Comment:

Item 3.19, Maternity Services, has not been changed. It reads the same as the replaced amendment. The statement is not in compliance with ACA 23-86-115 (b)(2) which reads...."The conversion policy shall not exclude coverage for pregnancy or other illnesss or injury on the grounds of a preexisting condition, provided that the combination of time served under the group and the conversion policy equals or exceeds any waiting periods under the group policy or contract. Moreover, the conversion policy shall include benefits for maternity coverage for any pregnancies in existence at the time of conversion.....".

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Amendment to Conversion Evidence of Coverage	QCA HMO (01-01-05) Amended		Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement	Initial			QCA Conversion

	Conversion	or Rider		Amendment Aug 2011 Revised Final.pdf

Previous Version

Amendment to Conversion Evidence of Coverage	*QCA HMO (01-01-05) Amended Conversion*	*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*	QCA Conversion Amendment Aug 2011 Revised Final.pdf
Amendment to Conversion Evidence of Coverage	*QCA HMO (01-01-05) Amended Conversion*	*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*	QCA Amendment To Conversion Aug 2011.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: Please withdraw the QCA Conversion (8-11) form.

Related Objection 1

Applies To:

- Conversion Evidence of Coverage Certificate, QCA Conversion (8-11) (Form)

Comment:

As discussed in our telephone conversation this morning, you were going to attempt to remove this attachment. It is still showing on the screen. If you would please respond to this objection letter and request that I withdraw the form, I will mark it withdraw upon my final disposition.

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Conversion Evidence of Coverage Certificate	QCA Conversion (8-11)		Policy/Contract/Fraternal Certificate	Initial			
Previous Version							
Conversion Evidence of Coverage Certificate	*QCA Conversion (8-11)*		*Policy/Contract/Fraternal Certificate*	*Initial*			QCA Conversion EOC Aug 2011.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Jim Couch, Niki Thomas

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/28/2011
Submitted Date	07/28/2011
Respond By Date	

Dear Jim Couch,

This will acknowledge receipt of the captioned filing.

Objection 1

- Health - Actuarial Justification (Supporting Document)

Comment:

As discussed in our recent telephone conversation, it is my understanding that you wish to replace this actuarial memo in order to clean up language.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/28/2011
Submitted Date	07/28/2011

Dear Rosalind Minor,

Comments:

Response 1

Comments: I have removed references in the actuarial justication to the QCA Conversion (8-11) evidence of coverage which we are withdrawing from the filing.

Related Objection 1

Applies To:

- Health - Actuarial Justification (Supporting Document)

Comment:

As discussed in our recent telephone conversation, it is my understanding that you wish to replace this actuarial memo in order to clean up language.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Health - Actuarial Justification

Comment: Please see attached.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Amendment to Conversion Evidence of Coverage	*QCA HMO (01-01-05) Amended Conversion*		*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*			QCA Conversion Amendment Aug

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

			2011 Revised Final.pdf

Previous Version

Amendment to Conversion Evidence of Coverage	*QCA HMO (01-01-05) Amended Conversion*	*Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider*	*Initial*	QCA Amendment To Conversion Aug 2011.pdf

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
QCA Conversion Rate Summary Eff Aug 2011	QCA Conversion (8-11) and QCA HMO (01-01-05) Amended Conversion	Revised	*Previous State Filing Number* *Percent Rate Change Request* 0	
Previous Version				
QCA Conversion Rate Summary Eff Aug 2011	*QCA Conversion (8-11) and QCA HMO (01-01-05) Amended Conversion*	*New*	*Previous State Filing Number* *0*	

Sincerely,
Jim Couch, Niki Thomas

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/21/2011
Submitted Date	07/21/2011
Respond By Date	

Dear Jim Couch,

This will acknowledge receipt of the captioned filing.

Objection 1

- Conversion Evidence of Coverage Certificate, QCA Conversion (8-11) (Form)
- Amendment to Conversion Evidence of Coverage, QCA HMO (01-01-05) Amended Conversion (Form)

Comment: Under item 2.3, Network Provider Participation, there needs to be a phone number and/or mailing address for the enrollees to use that do not have access to a computer and cannot get the online directory listing.

Objection 2

- Conversion Evidence of Coverage Certificate, QCA Conversion (8-11) (Form)
- Amendment to Conversion Evidence of Coverage, QCA HMO (01-01-05) Amended Conversion (Form)

Comment: Under item 3.19, Maternity Services, it is stated that ...."The following maternity services are covered only if you and your enrolled spouse is pregnant as of the effective date of this Certificate....".
This statement does not appear to be in compliance with ACA 23-86-115 (b)(2).

Objection 3

- Conversion Evidence of Coverage Certificate, QCA Conversion (8-11) (Form)
- Amendment to Conversion Evidence of Coverage, QCA HMO (01-01-05) Amended Conversion (Form)

Comment: On Page 27, item 44, there is an exclusion for Gastric Electrical Stimulators. This exclusion is not in compliance with ACA 23-99-418(HB 1915) which is a requirement for health insurance plans to provide coverage for gastric pacemakers, etc. This new law is effective 7/1/11.

Objection 4

- Conversion Evidence of Coverage Certificate, QCA Conversion (8-11) (Form)
- Amendment to Conversion Evidence of Coverage, QCA HMO (01-01-05) Amended Conversion (Form)

Comment:
The pre-existing provision does not seem to be in compliance with ACA 23-86-115(b)(2) which states that the conversion policy shall not exclude coverage for pregnancy or other illness or injury on the grounds of a preexisting condition, provided that the combination of time served under the group and the conversion policy equals or exceeds any waiting periods under the group policy or contract.

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:
Jim Couch on 07/24/2011 04:29 PM
Last Edited By:
Rosalind Minor
Submitted On:
07/28/2011 01:18 PM
Subject:
QCA Conversion Policy 8/11
Comments:
Plese find attached the red-lined version of the proposed Certificate for the QCA Conversion Poliy (8-11) which is referred to in my responses to your objections.

CONVERSION EVIDENCE OF COVERAGE CERTIFICATE

Attached is the Benefits Summary indicating name, benefits, Out-of-Pocket Limit amount, type of coverage, Preexisting Condition exclusion period, and effective date.

IMPORTANT NOTICE

COVERED SERVICES RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN VERY LIMITED CIRCUMSTANCES AS SET FORTH IN YOUR BENEFITS SUMMARY ARE NOT COVERED. REFER TO YOUR BENEFITS SUMMARY.

THIS COVERAGE CONTAINS A PREEXISTING CONDITION LIMITATION. REFER TO THE BENEFITS SUMMARY.

The benefits in this Certificate do not necessarily equal or match those benefits provided in your previous group policy.

Underwritten by:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
www.qualchoice.com

IMPORTANT QUALCHOICE CONTACT INFORMATION

QualChoice is committed to providing better customer support. That includes making it easy for you to contact us. You are always welcome to call us with any questions or concerns.

Website Address:

www.qualchoice.com

Our Customer Service Department can be reached:

Toll Free at (800) 235-7111

Locally at (501) 228-7111

Our QCARE Coaches can be reached:

Toll Free at (888) 795-6810

Our "Ask a Nurse" assistance line can be reached:

Toll Free at (866) 232-0447

TABLE OF CONTENTS

1. INTRODUCTION TO YOUR CERTIFICATE

1.1. Certificate

QCA Health Plan, Inc. Inc. ("QualChoice" also referred to as "us", "we" or "our") is a licensed Health Maintenance Organization. QualChoice has a certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone number is (501) 228-7111 or toll free (800) 235-7111.

This is your Evidence of Coverage Certificate (the "Certificate") for health care Benefits with us. This Certificate is a legal document between QCA Health Plan, Inc. and you to provide Covered Services subject to the terms, conditions, exclusions and limitations included herein.

1.2. Changes to This Certificate

We may from time to time modify this Certificate through a "Rider" and/or "Amendment" that may change certain provisions of this Certificate. When this happens we will send you a new Certificate, Rider or Amendment.

1.3. Key Information

For purposes of this Certificate, "you" or "your" means the Certificate Holder.

Only we have the right to change, interpret, modify, withdraw or add Benefits, or terminate this contract, as permitted by law, without your approval.

On its effective date, this Certificate replaces and overrules any certificate that we may have previously issued to you. This Certificate will in turn be overruled by any certificate we issue to you in the future.

Your coverage under this Certificate begins at 12:01 a.m. on the effective date, which is the day following the termination of your coverage under the employer group policy. We will continue your coverage unless and until you or we terminate it for any of the reasons described in this Certificate. We determine your eligibility for Benefits under this Certificate.

This Certificate and Benefits Summary describe your Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The Benefits Summary provided to you is an integral part of this Certificate. In the event this Certificate and the Benefits Summary conflict, the Benefits Summary will control. You should locate and familiarize yourself with the Benefits Summary.

This Certificate describes some special procedures with which you must comply.

To the extent that state law applies, the laws of the State of Arkansas shall govern this Certificate.

We have capitalized certain words in this Certificate. Those words have special meanings and, unless defined otherwise elsewhere, are defined in Section 11, "Definitions".

2. HOW THIS PLAN WORKS

This Certificate provides you with a flexible choice in selecting options in obtaining health care services and how your choice may financially impact you. We encourage you to utilize a Network Primary Care Physician to assist in the coordination of your health care services under this Certificate. The utilization of a Network Primary Care Physician is a matter you control and you are not required to notify us of your Network Primary Care Physician relationship. You are always encouraged to seek care directly from a Network Primary Care Physician first. You may also seek care with any Network Physician or Provider under this Plan without a Referral. Consult your Benefits Summary to identify Covered Services and Cost Sharing amounts.

2.1 In-Network Benefits

In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider or at a Network Facility; or
2. Emergency health services meeting the QualChoice payment guidelines.

Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and meets either of these requirements will be processed as an In-Network Benefit. Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and does not meet either of these requirements will not be covered.

You should validate the status of a Network Provider by accessing the on-line directory at any time or calling Customer Service during normal business hours.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in your Benefits Summary.

You may seek Covered Services from any Network Primary Care Physician or from other Network Physicians without a Referral. Coverage for services in the office is at the primary care physician benefit level when you seek Covered Services directly from any Network Primary Care Physician. Coverage for services in the office is at the specialist benefit level when you seek Covered Services from any other Network Physician. You should validate the status of a Network Provider by calling Customer Service or accessing the on-line provider directory. Please refer to your Benefits Summary for details.

2.2 Out-of-Network Benefits

As described in your Benefits Summary, services provided by an Out-of-Network Provider are not covered unless otherwise stated in your Benefits Summary or unless prior authorization for coverage as an In-Network Benefit is received from us. Any amounts that QualChoice allows for Covered Services provided by an Out-of-Network Provider will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary for details:

1. **Certificate Provision:** The Benefits Summary or this Certificate specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Certificate, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Continuity of Care, Pregnancy, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage you were receiving obstetrical care from an Out-of-Network Provider for a pregnancy covered under the terms of this Certificate, that you were in the third trimester of your pregnancy on the effective date of your coverage, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits;
5. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will

continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;

6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Certificate, that you were in the third trimester of your pregnancy on the date that the Provider left the PPO, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing QualChoice, Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3 Network Provider Participation

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at an In-Network Benefit level. You may search the directory on our website at www.qualchoice.com or by calling our Customer Service Department at (800) 235-7111. Because contractual agreements can change, you should verify that a physician or provider is a Network Provider before you seek care.

We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if your Covered Services for that condition are approved by us prior to receiving the service.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A referral, whether written or oral, by a Network Provider to an Out-of-Network Provider; or
2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Provider to provide and coordinate all future Covered Services. If you do not make a change to a single Network Provider within 31 days of the date we notify you, we will assign a single Network Provider to you.

2.4 Cost Sharing Requirements

You must share in the cost of your Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult your Benefits Summary to determine the amounts of your payments under these Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill you for

the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all charges. **These additional charges could amount to thousands of dollars in additional out-of-pocket expenses for which you are responsible.**

1. **Deductible:** The Deductible is a certain fixed dollar amount per Calendar Year, per person as set forth in your Benefits Summary.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time you receive a Covered Service to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket Limits for each Enrollee or family. Please see your Benefits Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of the Maximum Allowable Charge for the cost of Covered Services you must pay. Coinsurance payments are in addition to Deductibles or Co-payments. Your Benefits Summary contains your Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided to you.
4. **Limits on Your Out-of-Pocket Payments:** You will no longer have to pay Coinsurance for the remainder of the Calendar Year after you have met the Out-of-Pocket Limit during the Calendar Year. Your Benefits Summary lists your Out-of-Pocket Limit for Coinsurance. Coinsurance is the only amount that will apply towards your Out-of-Pocket Limit. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are your responsibility and do not count toward meeting the Out-of-Pocket Limit. Once your Out-of-Pocket Limit has been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge.

2.5 Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Certificate, and regardless of any other communications or materials you may receive in connection with your Certificate, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in . This standard applies to all sections of this Certificate.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In

making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Certificate. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.1.

2.6 Exclusion and Limitations

Some services are excluded from coverage and other services have specific coverage limitations.

This Certificate refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

Consult your Benefits Summary, Medical Policies, and Section 4.0 for information on benefit limitations and exclusions.

2.7 Enrollees Living Outside Service Area For More Than 90 Days

Enrollees that will live, work, or attend school outside the Service Area for more than 90 consecutive days should notify us. The Enrollee uses his/her QualChoice identification card to access Covered Services. Covered Services are processed at the In-Network Benefit level when provided by a QualChoice National Network (QCNN) healthcare provider. Covered Services for services not provided by a QualChoice National Network (QCNN) provider are will not be covered.

Enrollees who may use the QCNN for In-Network Benefits are:

1. Dependent students who are attending school outside the Service Area for at least 90 consecutive days, with renewal required annually; or
2. Dependent spouses and children who are living outside the Service Area for at least 90 consecutive days, with renewal required annually.

Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization for those services that we require to be pre-authorized (see Section 2.11) to receive Benefits at the In-Network Benefit level when accessing care from the QualChoice National Network (QCNN). It is the responsibility of the Enrollee to obtain the pre-authorization for Covered Services. QCNN providers are not responsible for obtaining a pre-authorization for services.

2.8 Coverage While Traveling Out of the Service Area

We cover the cost of Emergency health services an Enrollee incurs while traveling outside of the Service Area, but within the United States. An Enrollee is encouraged to seek services for Emergency health services from health care providers participating in the QualChoice National Network (QCNN) when the Enrollee is out of the Service Area. An Enrollee may limit out-of-pocket expenses for Emergency health services while outside of the Service Area to applicable Cost Sharing Amounts by accessing such care from a QCNN provider.

If care is accessed by an Enrollee from providers not participating in the QCNN, Covered Services received from such providers are not covered except in very limited circumstances as set forth in you Benefits Summary. We will deny coverage for routine and follow up care after Emergency health services unless a Network Provider in Arkansas performs the services.

The QualChoice identification card contains contact information for the QCNN. QCNN providers may be identified by calling the number on the identification card. The Enrollee must present their QualChoice identification card to the servicing provider indicating participation in the QCNN in order to receive this benefit. Submit a Claim for Benefits directly to us for processing. Provisions for

Emergency health services as set forth in Section 3.10 must also be followed to receive maximum Benefits.

Dependents who have notified QualChoice that they reside outside the Service Area may access the QCNN providers and facilities for Covered Services at the In-Network benefit level upon prior approval by QualChoice.

2.9 General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of this Certificate. A final determination of eligibility is made at the time a Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a healthcare care provider, provided within the scope of that healthcare provider's license, and rendered in accordance with professionally recognized standards of care.

During the first year of this Certificate, the Benefits payable under this Certificate shall not exceed those that would have been payable had your Benefits under your former employer's group policy remained in force and effect.

2.10 Administration and Interpretation of this Certificate

We have sole and exclusive discretion to interpret the Benefits provided under this Certificate as well as all other provisions, terms, conditions, limitations and exclusions in the Certificate and to make factual determinations related to the Certificate and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Certificate. Subject to applicable law or regulation we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate the Certificate, in our sole discretion, without prior notice to or approval by Enrollees. Changes to this Certificate will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.11 Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services must be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

Your responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations for you. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QualChoice National Network (QCNN). QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not responsible for obtaining required pre-authorizations.

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if your clinical status has changed sufficiently that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service department. Any of our pre-authorization decisions may be appealed by following

the procedures in Section 7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.12 Utilization Management

We cover Medically Necessary services as described in Section 2.5. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.13 Case Management

We provide a Case Management program. Case Management assists you to make the best use of your Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, high-risk pregnancy, transplants, oncology and neonatology.

2.14 QCARE

QCARE is our population health management program that facilitates access to medical services, and provides tools and self-management assistance to our Enrollees who have chronic medical conditions, such as diabetes, hypertension, and asthma. We work one-on-one with Enrollees to help them understand their illnesses better. We also educate Enrollees on treatment options so that the Enrollee can better manage their health.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this section subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11, and to all other applicable conditions, limitations and exclusions of this Certificate. **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.1 Advanced Diagnostic Imaging

Advanced diagnostic imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of your Certificate as set forth in your Benefits Summary; and
2. Pre-authorization is required for these tests. The requirements for pre-authorization are detailed in Section 2.11 must be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2 Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations as set forth in this Certificate. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in your Benefits Summary, and the following criteria:

1. When an accident or other medical Emergency occurs, we cover transport to the nearest facility when Emergency services are required;
2. We cover ambulance transportation from one facility to another facility for one of the reasons identified below as long as it is coordinated through the QualChoice Care Management department:
    A. To access equipment or expertise necessary to care for you properly;
    B. To receive a test or service which is not available at the facility where you have been admitted and you return after the test or service is completed;
    C. To transport you from an Out-of-Network Facility to a Network Facility; and
    D. To transport you directly from an acute care setting to an alternate level of care.

3.3 Complications of Pregnancy

Coverage is provided for treatment of Complications of Pregnancy when performed or prescribed by a physician subject to the Deductible and Coinsurance amounts specified in the Benefit Summary.

3.4 Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice prior to services being provided. Benefits are subject to a maximum limit per Enrollee per accident. See your Benefits Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery ("D.D.S.") or a Doctor of Medical Dentistry ("D.M.D."). The damage must be severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

The physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth; or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, or no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

If the Enrollee is under age 15, reimbursement for dental care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of QualChoice, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Enrollee is in force when the treatment is rendered.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position; reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5 Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility; and

2. The situation meets Medical Necessity criteria, and the patient is:
    A. A Child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible;
    B. A person with a serious mental health condition that prevents use of local anesthesia for the procedure;
    C. A person with a serious physical condition making facility care necessary for the safe performance of dental work; or
    D. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required (see Section 2.11). **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.6 Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis; and
7. Incision of accessory sinuses, salivary glands or ducts.

3.7 Dental – Other

Other dental care and orthodontic services are not covered.

3.8 Diabetes Management

Diabetes self-management training is limited to one program per lifetime per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9 Durable Medical Equipment

Durable Medical Equipment (DME) is equipment primarily and customarily serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used. DME is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person.

You must obtain all DME through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition of and description of coverage for orthotics and prosthetic devices and services are in Sections 3.22 and 3.27 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a Network DME Provider. It is your responsibility to confirm this with your physician. If DME dispensed by your physician is not from a Network DME Provider, you can obtain a prescription from your physician for the DME and contact us to assist in obtaining the equipment. Failure to insure all DME is obtained from a Network DME Provider will result in denial of Benefits.

3.10 Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section 11.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 11) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United States, are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling the number at the front of this Certificate.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If in an Emergency an Enrollee goes to an Out-of-Network Facility's emergency room for treatment and the Enrollee is admitted at that Out-of-Network Facility for further care or in-patient treatment, *the Enrollee, a family member or the Facility must notify our Care Management Department once the Enrollee is stabilized, but in no event more than forty-eight (48) hours after initial treatment*. Failure to notify us within the specified forty-eight (48) hour time requirement may result in a denial of Benefits. Upon receipt of such notification, we may either authorize the Enrollee's admission to, or further treatment at, the Out-of-Network Provider hospital, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Provider facility, the admitting physician, and the Enrollee's Network Provider. If the Enrollee stays at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the facility and other Out-of-Network Providers providing care to you.

3.11 Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

Benefits also include one routine vision exam, including refraction, to detect vision impairment by a Network Provider once every 24 months. Refraction is only covered when provided in conjunction with a routine vision examination.

Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery and for treatment of disease as specified in Section 4.1.

3.12 Family Planning Services

Coverage is provided for voluntary sterilizations (vasectomies and tubal ligations) except as excluded in Section 4.1

3.13 Home Health Services

Coverage is available for the following services provided in your home when your medical condition supports the need for such services, the services are ordered by a physician, and are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. (See your Benefits Summary for visit limitation details.)

The following services provided by a licensed home health agency in your home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled care, that is, skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse, is not Custodial Care;
2. Physical, occupational and speech therapy services;
3. Medical supplies provided by the home health agency during the course of approved care; and
4. Home services by a nurse midwife, except home deliveries.

3.14 Home Infusion Therapy

The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.
4. When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15 Hospice Services

Hospice services must be pre-authorized and arranged by a QualChoice Case Manager. Consult your Benefits Summary for applicable Cost Sharing Amounts. Coverage is available for Enrollees with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following hospice services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program, provided the hospice program was pre-authorized by QualChoice:

1. In-patient care in a freestanding hospice, a hospice unit within a facility or skilled nursing facility, or in an acute care facility bed; and
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including, but not limited to, the following:
    A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
    B. Respiratory therapy;
    C. Social services;
    D. Nutritional services;
    E. Laboratory examinations;
    F. Chemotherapy and radiation therapy when required for control of symptoms;
    G. Medical supplies; and
    H. Medical care provided by a physician.

3.16 Facility – In-patient Care

In-patient facility care Benefits are available for services and supplies received during the facility stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any facility services unless the service is provided to the Enrollee by an employee of the facility, the facility bills for the service, the service is not primarily for convenience, and the facility retains the payment collected for the service.

Hospital in-patient care is also subject to the following conditions:

1. We cover Medically Necessary acute in-patient facility care for the care or treatment of the Enrollee's condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance.
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy.
4. We do not provide Benefits while an Enrollee is waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
    A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
    B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
    C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred;
    D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment.

    .
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.11. Please call the number listed on your identification card to notify us of the admission.

3.17 Injectible Prescription Medications

Benefits are available for Injectible Prescription Medication(s) received only when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility based upon the Maximum Allowable Charge for the Injectible Prescription Medication and subject to the applicable Cost Sharing Amounts specified in your Benefits Summary.

3.18 Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19 Maternity Services

The following maternity services are covered ***only*** if you or your enrolled spouse is pregnant as of the effective date of this Certificate:

1. **Fetal Testing:** Amniocentesis or chorionic villus sampling is covered when performed in accordance with recognized standards of care.
2. **In-patient Hospital Stays; Statement of Rights Under the Newborns' and Mothers' Health Protection Act.** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any facility length of stay in connection with childbirth for the mother or newborn child to less than 48

hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

We will pay for an in-patient facility stay of at least 48 hours for the mother and newborn Child following a normal vaginal delivery. We will pay for an in-patient facility stay of at least 96 hours for the mother and newborn Child following a cesarean section delivery. However, we may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact our Customer Service department.

3. **Maternity and Obstetrical Care:** Coverage is provided for Maternity and Obstetrical Care, including routine prenatal care, postnatal care, delivery in an in-patient facility setting, and any related complications. Routine prenatal care includes coverage of only one routine ultrasound usually done between the 16th and 22nd week of pregnancy. If additional ultrasounds are needed due to Medical Necessity, pre-authorization is required. QualChoice provides special prenatal programs designed to benefit you and your baby during pregnancy. These are available at no additional cost and are voluntary. To sign up, you should contact us as early as possible during your pregnancy.
4. **Midwives:** Coverage is provided for services received from a certified nurse midwife, but only if that nurse midwife is a Network Provider and the delivery is done in an in-patient facility setting.
5. **Newborn Care in the Hospital:** A newborn Child of the Certificate Holder or the Certificate Holder's spouse will be covered from the date of birth, including use of newborn nursery and related services, provided the Child's coverage becomes effective on his or her date of birth subject to the requirements of Section 5.0 being met.

3.20 Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a Network Physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds $2,400 per year per person.

The covered amount will be the incurred cost of medical food or low protein modified food products that are in excess of the $2,400 per year per person, subject to the Cost Sharing Amounts specified in your Benefits Summary.

3.21 Medical Supplies

Medical supplies are items that are consumed or reduced with use so that they cannot be repeatedly used, are primarily or customarily used for medical purposes, and are generally not useful in the absence of an illness or injury. Medical supplies do not include medications or implants. Medical supplies are only covered when prescribed by a physician and when Medically Necessary.

The following conditions will also apply to coverage for Medical supplies:

1. Coverage for medical supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for medical supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used; and
3. Coverage for medical supplies is limited to a 31-day supply per month.

3.22 Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does ***not*** include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.23 Outpatient Services

Outpatient Covered Services are as follows:

1. Outpatient Facility Services: Subject to all of the terms, conditions, limitations and exclusions of this Certificate, Covered Services shall include services provided in a licensed outpatient facility or at a facility outpatient department. Examples include diagnostic services,

radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for in-patient admission.

2. Outpatient Surgery: Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient facility setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service.

We cover Medically Necessary surgical services. We apply multiple surgical procedures reduction when the same provider performs two or more surgical procedures on the same Enrollee within the same operative session.

3.24 Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefits Summary.

3.25 Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com or you may contact our Customer Service department to obtain specific coverage guidelines.

3.26 Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Certificate and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).
2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;
5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.27 Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does ***not*** include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.28 Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is ***not*** covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Certificate.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Enrollee;

2. Surgery performed on a child for the correction of a cleft palate or cleft lip, removal of a port-wine stain (**only** on the face), or correction of a congenital abnormality. In order to be covered, such corrective surgery for a congenital defect must be performed when the child is twelve (12) years or younger, unless, in its sole discretion QualChoice determines that due to the complexity of the procedure, such surgery could not be performed prior to the child's twelfth (12^{th}) birthday. Dental care to correct congenital defects is not a covered benefit;
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery;
4. In connection with a mastectomy eligible for coverage under this Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphademas; or
5. Reduction Mammoplasty that meets our criteria for coverage (which you may request to obtain a copy from us) is a Covered Service subject to Deductible and 50% Coinsurance. Pre-authorization is required.

Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. As further explained in Section 4.1, we do not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services.

3.29 Skilled Nursing Facility and In-patient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute in-patient rehabilitation facility when provided immediately after hospitalization in an acute care general facility for a covered illness or injury. Care will be limited to the number of covered days provided by your Certificate and if Medically Necessary for continued improvement. See your Benefits Summary for details.

3.30 Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a facility. Refer to your Benefits Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.31 Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Certificate. Consult your Benefits Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your QualChoice identification card to obtain pre-authorization before your evaluation for transplant and placement on any transplant list***. Once the evaluation is complete, you must obtain an additional pre-authorization for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the Certificate as follows:
    A. **Transplant Covered Services:** We will cover any facility, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us**.

B. **Facility Care:** We cover all in-patient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network Facility, we may require Network Providers at a Network Facility to provide some follow-up care.
C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. This coverage applies to the donor whose organ has been selected to be used in the transplantation. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health plan indicating coverage or denial for the donation.) Please refer to your Benefits Summary for Cost Sharing Amounts and lifetime maximums.

3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   A. Aplastic anemia
   B. Wiscott-Aldrich syndrome
   C. Albers-Schonberg syndrome
   D. Hemoglobinopathy, e.g., Thalassemia major
   E. Myelodysplastic syndromes – primary and acquired
   F. Immunodeficiency syndrome
   G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   I. Neuroblastoma, stage III or IV
   J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   K. Chronic myelogenous leukemia in the chronic phase
   L. Multiple myeloma
   M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse
   N. Chronic Lymphocytic Leukemia
   O. Marrow failure, Fanconi's, red cell aplasia
   P. Amyloidoosis
   Q. Paroxysmal Nocturnal Hemoglobinuria

   This Certificate requires specific donor matches for certain procedures.

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Certificate. Cornea transplantation does not require pre-authorization.

IMPORTANT NOTE REGARDING TRANSPLANTATION SERVICES: It is important that you review and understand the benefit limitations for transplant services described in Section 4.2 of this Certificate.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This section describes those exclusions and limitations. One or more of our optional coverage riders may cover some of these items. If you have purchased riders, they will be provided to you in writing. Please refer to your Benefits Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1 Non-Covered Services and Exclusions from Coverage

1. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies

or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.

2. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted Child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges. For the purpose of this Certificate, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth. Refer to Section 5.1 for information regarding coverage of adopted children.
3. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
4. **Against Medical Advice:** We will not cover any services related to an in-patient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
5. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as the following:
   A. Acupuncture;
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy;
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy; and
   K. Massage Therapy (except as provided for in QualChoice's Medical Policies).
6. **Baby Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
7. **Blood and Blood Donation:** We do not pay for any charges associated with blood donations. We do not pay for procurement, or storage, of donated blood. We do not cover umbilical cord blood banking or blood banking for blood or blood products with unscheduled future use. We do cover the charges for administration of blood and blood products. We do cover blood or blood product banking charges for covered procedures planned in the next 180 days.
8. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
9. **Care Plan Oversight**: Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
10. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
11. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in facilities not licensed as short-term acute care general facility or skilled nursing facilities, for example:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;
    D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis facility;
    E. Infirmaries at camps or schools;
    F. Hospitals for treatment of a Mental Health or Substance Use Disorder;
    G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);

H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.29);
I. Extended care, chronic care, or transitional facilities or facilities (except as covered under Section 3.29); or
J. Other facilities and institutions, which do not meet our criteria for short-term acute care general facility or skilled nursing facilities

12. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
13. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year annual treatment limits or lifetime maximums as shown on the Benefits Summary.
14. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
15. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
16. **Chemical Ecology:** Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
17. **Chiropractic Care:** Chiropractic care services are not covered.
18. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
19. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the-counter (without a prescription) are not covered.
20. **Convenience Items or Services:** We will not cover items or services utilized primarily for your convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to, a cot, hot water bottle, telephone, television, television rental charges, whirlpool bath, automobile/van conversion, wheel chair ramp, and home modifications.
21. **Cosmetic or Reconstructive Services**: Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. We will not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services. Procedures or services that change or improve appearance without improving physiological function are also not covered. Procedures or services that correct a physical developmental defect present at the time of birth without improving or restoring physiologic function are considered cosmetic procedures. The fact that an Enrollee may suffer psychological consequences as a result of an injury, sickness or developmental defect present at the time of birth, does not make the service Medically Necessary.
22. **Custodial Care:** We do not cover Custodial Care. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial Care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding, or range of motion exercises. Non-covered Custodial Care may be rendered in a facility, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.
23. **Dental Care:** This Certificate does not provide Benefits for dental care. Except as otherwise stated in this Certificate, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;

E. Treatment of periodontal disease;
F. Treatment of dental abscess;
G. Treatment of dentigerous cysts;
H. Removal of soft tissue supporting or surrounding teeth;
I. Orthodontia (including braces);
J. False teeth;
K. Orthognathic surgery; or
L. Any other dental services you may receive, except as specifically set out in your Benefits Summary.

24. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.
25. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.
26. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit, and motor dysfunctions are not covered. Except for an autism screening occurring one time between the ages of 1 and 4, this includes an exclusion for developmental delay associated with autism spectrum disorder.
27. **Dietary and Nutritional Services:** Unless dietary supplies are the sole source of nutrition for the Enrollee (see Section 3.21 - Medical Foods), any services or supplies provided for dietary or nutritional services, including, but not limited to, medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a physician or acquired over-the-counter, are not a covered.
28. **Domestic Partners:** We do not provide coverage for domestic partners of the same sex or opposite sex.
29. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.
30. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
31. **Electronic Consultations:** We do not cover charges for a healthcare provider's consultation by telephone, email, or other electronic communications with you or another healthcare provider.
32. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, are not covered. However, subject to all terms, conditions, exclusion and limitations as set forth in this Certificate; coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.
33. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is not covered. However, subject to all terms, conditions, exclusion and limitations in this Certificate, and at the sole determination of QualChoice, coverage may be provided for enhanced external counterpulsation for the treatment of Enrollees with coronary artery disease documented by coronary artery catheterization. Our Medical Policy regarding enhanced external counterpulsation is available on our website www.qualchoice.com or you may contact our customer service department to obtain specific coverage guidelines.
34. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.
35. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under this Certificate, on grounds of excessive use when it is the determination of our medical director that: (1) an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia, or by the QualChoice Pharmacy & Therapeutics Committee; or (2) an Enrollee has obtained or attempted to obtain the same medication

from more than one physician for the same or overlapping periods of time; or (3) the pattern of prescription medication purchases, changes of physicians or pharmacy, or other information indicates an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider, or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use, or activity to evaluate for excessive use.

36. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a physician.
37. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.
38. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including, but not limited to, plantar fasciitis or tennis elbow, is not covered.
39. **First Aid Supplies:** We will not cover over-the-counter first aid supplies.
40. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, non-surgical care of bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations of this Certificate, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
41. **Foot Orthotics:** Foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.
42. **Fraud or Misrepresentation:** Health interventions or health services, including, but not limited to, medications obtained by unauthorized or fraudulent use of an Enrollee's QualChoice identification card or by material misrepresentation as part of your enrollment process or at other times, are not covered.
43. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you and/or the provider did not think there would be insurance when the provider chose not to charge for the care provided.
44. ~~**Gastric Electrical Stimulators:** Gastric electrical stimulators or electrogastrography are not covered.~~
45.44. **Government Programs:** We will not pay for Covered Services to the extent Benefits for such services are payable under Medicare or any other federal, state or local government program.
46.45. **Group Therapy:** Group therapy or group counseling at any time in any setting by any provider is not covered.
47.46. **Hair Loss or Growth:** Wigs, hair transplants, or any medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.
48.47. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including

special computers, are not covered. Fitting or repair of such devices is not covered. Cochlear implants are the only exception to this exclusion as specified in Section 4.2(4).

~~49.~~48. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.

~~50.~~49. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants, and Nonmyeloalative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.31.

~~51.~~50. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.

~~52.~~51. **Illegal Acts:** Except as required by law, we will not cover health care services resulting from participation in a felony, riot, insurrection, or other illegal act, whether or not convicted.

~~53.~~52. **Illegal Uses:** Medications, drugs, or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or accidental injuries from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits are not covered.

~~54.~~53. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury, or prostate surgery.

~~55.~~54. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered.

~~56.~~55. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications, procedures, or other services for treatment of infertility. It does not matter whether the infertility service is diagnostic or therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:

A. Reversal of sterilization;
B. Pre-implantation testing;
C. Surrogate pregnancies;
D. Medical treatment of infertility;
E. Surgical treatment of infertility; and
F. In vitro fertilization

Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying cause of the infertility are detected or treated during such surgery.

~~57.~~56. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, where the Enrollee is on a cardiac transplant list at a facility where there is an ongoing cardiac transplantation program, the Certificate will cover infusion of inotropic agents.

~~58.~~57. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars, or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.

~~59.~~58. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.

~~60.~~59. **Learning Disabilities:** Services or supplies provided for learning disabilities, for example, reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties, are not covered.

~~61.~~60. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. is not covered.

~~62.~~61. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.

~~63.~~62. **Maintenance Therapy:** We will not cover maintenance therapy for physical therapy, occupational therapy, or speech therapy.

~~64.~~63. **Mammoplasty:** Except as provided in Section 3.28, we do not cover mammoplasty for reasons of augmentation or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.

~~65.~~64. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party such as, but not limited to, an employer, licensing board, recreation council, or school.

~~66.~~65. **Marriage and Relationship Counseling:** Marriage and relationship counseling services are not covered.

~~67.~~66. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms or the preparation or copying of medical records.

~~68.~~67. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services, or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications, counseling, weight maintenance programs, gastric stapling, gastric bypass, or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.

~~69.~~68. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including, but not limited to, a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.

~~70.~~69. **Mental Health or Substance Use Disorder:** Services of any kind or nature for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse are not covered. Services that are excluded include, but are not limited to:

A. Testing, evaluation, assessment and/or treatment of every diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
B. Hypnotherapy;
C. Treatment of behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
D. Hospitalization for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse;
E. Evaluation of psychosocial factors potentially impacting physical health problems and treatments, including health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems;
F. Services for treatment of eating disorders are not covered; this exclusion includes treatment for anorexia, bulimia and other eating disorders; and
G. Family counseling in conjunction with an Enrollee's individual crisis therapy.

~~71.~~70. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of an Enrollee's refusal to comply with a physician's or other provider's recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.

~~72.~~71. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.

~~73.~~72. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.

~~74.~~73. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.

~~75.~~74. **Over-the-Counter Medications:** Medications (except insulin) which do not by law require a prescription from a physician are not covered.

~~76.~~75. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.

~~77.~~76. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.

~~78.~~77. **Percutaneous diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.

~~79.~~78. **Percutaneous Kyphoplasty:** Percutaneous kyphoplasty is not covered.

~~80.~~79. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.

~~81.~~80. **Performance Enhancement:** We will not cover medical, surgical, or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic, or recreational performance, including, but not limited to, work hardening programs, back schools, programs of general physical conditioning, athletic trainers, and special or specially modified surgical procedures designed to enhance performance above normal.

~~82.~~81. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.

~~83.~~82. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.

~~84.~~83. **Pre-existing Conditions:** Benefits for the treatment of a Pre-existing Condition are excluded until you have had continuous coverage under your previous group policy and this Certificate combined for 12 months. This exclusion does not apply to coverage for maternity services for a pregnancy in existence as of the effective date of this Certificate or to an Enrollee under the age of 19.

~~85.~~84. **Pre-Implantation Genetic Diagnosis:** We do not cover pre-implantation genetic diagnosis or treatment.

~~86.~~85. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.

~~87.~~86. **Prescription Drugs:** We do not cover medications prescribed for an Enrollee for use on an outpatient basis, that is, medications not dispensed or administered when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility.

~~88.~~87. **Private Duty Nurses:** We will not cover private duty nurses.

~~89.~~88. **Private Room:** We do not cover a private facility room. We will pay the most common charge for semi-private accommodations. If you are charged for a private room, you must pay the difference between the charges for a private room and our payment.

~~90.~~89. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.

~~91.~~90. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.

~~92.~~91. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:

A. Obtaining employment;
B. Maintaining employment;
C. Obtaining insurance;

D. Obtaining professional or other licenses;
E. Engaging in travel;
F. Athletic or recreational activities; or
G. Attending a school, camp, or other program.

93. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
94. **Rest Cures:** Services or supplies for rest cures are not covered.
95. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
96. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.
97. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental) meeting the definition of a Mental Health or Substance Abuse Disorder.
98. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
99. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Certificate as being a Covered Service.
100. **Services Received Outside the United States:** Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of QualChoice.
101. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
102. **Sexual and Gender Identity Disorders**: Any services related to the treatment of sexual and gender identity disorders are not covered.
103. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome are not covered, except when short stature is caused by laboratory documented growth hormone deficiency.
104. **Sleep Apnea, Portable Studies:** Studies for the diagnosis, assessment, or management of obstructive sleep apnea, not continuously attended by a qualified technician, are not covered.
105. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is included with this Certificate, treatment of caffeine, smoking, or nicotine addiction, smoking cessation prescription medication products, including, but not limited to, nicotine gum and nicotine patches, are not covered.
106. **Snoring:** Devices, procedures, or supplies to treat snoring are not covered.
107. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.
108. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.
109. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Certificate, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical, and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including, but not limited to, the shortening of the mandible or maxillae or the correction of malocclusion.
110. **Thermography:** Thermography, which is the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
111. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or facility or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this

Certificate prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Enrollee from the third party, or its insurer. Please refer to Section 8 and Section 10.8 for further information concerning repayment of Benefits.

112. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
113. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
114. **Trans-telephonic Home Spirometry:** Trans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
115. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for ground or air emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department. Refer to your Benefits Summary for limitations.
116. **Travel, School, Recreation, or Work Related Immunizations:** Except to the extent coverage is specifically provided in this Certificate as a preventive health benefit, we will not cover immunizations to fulfill requirements for international travel, school, recreation, or for work.
117. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.
118. **Vision:** Except as set forth in the Benefits Summary, we will not cover routine eye, services or tests, eyeglasses, contact lenses, and other vision care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes.
119. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglass and contact lenses (except the initial acquisition of one pair within the twelve months following cataract surgery up to $200 for frames and lenses), are not covered.
120. **Vitamins or Supplements:** Vitamins or nutrient supplements not available over the counter are not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism as described in Section 3.21 – Medical Foods.
121. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.
122. **Weight Control:** Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
123. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
124. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition, or disease arising from your employment. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law.
125. **Wound Treatment:** Blood derived growth factors are not covered.

4.2 Limitations to Benefits

Coverage is available for medical services or care as specified in this Section 4.2 subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11, and to all other applicable conditions, limitations and exclusions of this Certificate.

1. **Ambulance:** Transportation by ambulance of any kind is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult your Benefits Summary for benefit limitations.
2. **Auditory Brain Stem Implant.** One auditory brain stem implant per lifetime is covered for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone removal of bilateral acoustic tumors.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Cochlear Implants:** Coverage for cochlear implants is subject to a maximum lifetime benefit of $20,000 per Enrollee. Coverage is limited to one cochlear implant device, the surgical procedure, and one speech processor. Reimplantation of the same device is not covered. Pre-authorization is required.
5. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of facility or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
6. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Out-of Network DME is not covered. Please refer to your Benefits Summary for this annual limit.
7. **Genetic Counseling and Testing:** Genetic testing is generally not covered. Genetic testing is often done on blood or tissue samples sent by your physician to a laboratory. *For genetic counseling or testing to be covered, it requires pre-authorization.* Pre-authorization will only be given in accordance with QualChoice's Medical Policies which require the results of the genetic testing to affect choice of treatment or the outcome of treatment. We will not cover genetic counseling or testing to determine the likelihood of:
    A. Developing a disease or condition; or
    B. Disease or the presence of a disease in a relative; or
    C. Passing an inheritable disease, for example, cystic fibrosis, or congenital abnormality to an offspring.

    However, subject to all terms, conditions, exclusions and limitations set out in this Certificate, genetic testing of the products of an amniocentesis to determine the presence of a disease or congenital anomaly in the fetus or genetic testing of an Enrollee's tissue to determine if the Enrollee has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered if the test meets QualChoice's Medical Necessity criteria. Any approved genetic testing must be preceded by genetic counseling.
8. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Contract Year. The home health care visit limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
9. **Hospice Services:** Hospice services are limited to a maximum number of days of coverage per Enrollee. The hospice services day limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
10. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
11. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.

12. **Lifetime Maximum:** Consult your Benefits Summary and this Certificate for various lifetime maximum Benefits per Enrollee.
13. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Physicians and Network Facilities will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
14. **Medical Supplies:** Coverage of medical supplies is limited to a 31-day supply per month.
15. **Newborn Care:** We will cover Newborn Children of the Certificate Holder or spouse from the date of birth provided the Certificate Holder enrolls the newborn within 90 days after the date of birth.
16. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation, and cardiac rehabilitation services are limited to a maximum number of visits per Enrollee per Contract Year as reflected in your Benefits Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider will not be covered as set out in your Benefits Summary.
17. **Prosthetic and Orthotic Devices and Services.** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.
18. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Physicians for personal reasons. In such case, neither we nor any Network Physician or Provider shall have any further responsibility to provide care for the condition under treatment, unless you later recant the refusal and agree to follow the recommended treatment or procedure.
19. **Shoes and Shoe Inserts:** Custom molded and fitted shoes and shoe inserts are not covered except for an Enrollee with diabetes. Coverage for an Enrollee with diabetes for custom molded and fitted shoes and shoe inserts is subject to the following limitations:
    A. Two (2) pairs of custom molded and fitted shoes per year if the Enrollee is under 18 years of age and one (1) pair of custom molded and fitted shoes for an Enrollee 18 years of age or older; and
    B. Two (2) pairs of custom molded shoe inserts per year.
20. **Transplant Services:** Transplant services are subject to the following benefit maximums and limitations:
    A. Coverage for procurement and testing (per transplant) is limited to the amount reflected in your Benefits Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary ;
    C. We will not cover the transportation and/or lodging costs of the transplant recipient, transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs;
    D. Coverage is limited to no more than the number of transplants per Enrollee per lifetime as reflected in your Benefits Summary. We cover re-transplantation, but a re-transplant is considered a transplant and counts toward the transplant limit;
    E. Expenses for drugs related to avoidance of rejection of a transplanted organ are subject to the lifetime transplant maximum as reflected in your Benefits Summary;
    F. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission, or in complete remission less than two (2) years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small

or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis; and

G. **Transplants that are not pre-authorized by QualChoice Care Management Department are not covered.**

5. ELIGIBILITY CRITERIA

5.1 Who is Eligible for Coverage

Only you and your dependents who were covered under your original employer group policy on the date of termination of coverage under that employer group policy are eligible for coverage under this Certificate. You must list yourself and any of your eligible dependents you are electing to cover on the Enrollment Application to be eligible for coverage. If you do not list them on the Enrollment Application, they will not be eligible for coverage under this Certificate. You and your dependents must meet all eligibility requirements in this Certificate. The following members of your family may be eligible as dependents as long as they were covered under your original employer group policy on the date of termination of coverage under that employer group policy:

1. Your spouse, unless you are divorced or have annulled your marriage. Domestic partners are not eligible for coverage as a dependent under this Certificate.
2. Your Child until s/he becomes twenty-six (26) years of age. However, if your prior employer group policy is a grandfathered plan, your Child nineteen (19) years of age and older but who has not attained the age of twenty-six (26) years is eligible only if s/he is not otherwise eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.
3. Your incapacitated Child may be an eligible dependent. The incapacitated Child must be twenty-six (26) years of age or older and totally disabled due to continuous developmental or physical incapacity. The incapacitated Child must be primarily dependent on you for financial support and you must declare the incapacitated Child as a dependent on your federal income tax returns. The disability leading to mental or physical incapacity must have occurred before the Child reached age twenty-six (26) and while covered under this Certificate or other group medical insurance coverage. The Social Security Administration or a physician must medically certify the disability. In addition to this medical certification, we have the unilateral right to determine whether a Child is, and continues to qualify as an incapacitated Child. At any time, we may request a declaration of disability (or like document) supporting such dependent's incapacity and dependency. You must notify us if the incapacity or dependency is removed or terminated. Newly eligible Enrollees may enroll an incapacitated Child provided the disability commenced before the limiting age and a health benefit plan continuously covered the Child as your dependent since before the limiting age. Our determination of eligibility shall be conclusive.
4. Coverage for a Child whom you have adopted or for whom you have filed a petition for adoption shall begin on the date of the adoption or the date of the filing of the petition for adoption. You must submit an Enrollment Application to us within 60 days after the adoption or the filing of the petition. Coverage will begin subject to payment of all applicable premiums. The coverage shall begin from the moment of birth if the petition for adoption or adoption occurred and you submit the application for coverage to us within 60 days of the birth of the Child. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

Your coverage begins upon the effective date of this Certificate which is the day following your termination of your coverage under the group Certificate. You should contact our Customer Service Department for information concerning your eligibility requirements and effective date. You will not be eligible to enroll if you do not meet the eligibility rules of this Certificate.

Neither you nor your dependent will be eligible to enroll if:

1. You have had previous coverage with us terminated for causes described in Section 5.4(5) of this Certificate.
2. Such person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program.
3. Such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.
4. Such benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.
5. The benefits provided under subparagraph (2) above for such person, or benefits provided or available under the sources referred to in subparagraphs (3) and (4) above for such person, together with the benefits provided by this Certificate, would result in over-insurance according to our standards as filed with Arkansas Insurance Department, if any.
6. If such person is eligible for Medicare.

Coverage for newborn or adopted children in your family begins on the date they meet the eligibility requirements of this Certificate. Coverage for your newborn Child is effective as of the date of birth if you submit an Enrollment Application to us within 90 days of the date of birth of the Child or before the next premium due date, whichever is later. Coverage for your adopted Child is effective as of the date of the adoption if you submit an Enrollment Application to us within 90 days of the date of the adoption of the Child or before the next premium due date, whichever is later.

Coverage, subject to all other terms, conditions, exclusions and limitations of this Certificate, will be extended to an eligible Enrollee who is inpatient in a facility on the effective date of this Certificate. However, consistent with applicable law, if such eligible Enrollee is inpatient in a facility on the effective date of this Certificate and immediately prior to such effective date was covered by a group health plan that provides coverage for facility or medical services or expenses, coverage for benefits under that other group health plan will continue and it will be primarily responsible for those services and expenses associated with that facility admission. As the primary plan, that other group health plan will be responsible for those services and expenses until the end of that facility admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

If your Covered Dependent gives birth, the newborn grandchild is not eligible for coverage. If you, as the Child's grandparent, adopt or become the legal guardian of the Child, we will cover the Child from the effective date of the adoption or the legal guardianship.

5.2 Termination of Coverage

Your coverage under this Certificate will terminate in certain circumstances. We describe these circumstances below.

1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Certificate. Failure to remit premium payments to us in accordance with these terms may result in the suspension of Benefits for you and your Covered Dependents. In the event you do not respond timely to written and verbal demands for payment by us, coverage under this Certificate will be terminated retroactive to the last day of the month for which premium payment was received.
2. **Certificate Holder's Death:** Coverage for Covered Dependents under this Certificate will automatically terminate on the date of the Certificate Holder's death.
3. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.
4. **Termination of Your Marriage:** If you divorce, legally separate, or annul your marriage, the coverage of the Certificate Holder's spouse will automatically **terminate on the date of the** divorce, legal separation, or annulment. A court order requiring the Certificate Holder to provide coverage for the former spouse does not change the termination of coverage.

5. **Termination of Coverage of A Dependent Child:** The coverage of a Child under this Certificate will terminate automatically on the earliest of the following dates on which the Child:
    A. No longer meets the limiting age eligibility requirements;
    B. For a Child incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support; termination of coverage based upon age limitation(s) does not apply to a Child who qualifies as an incapacitated Child.
6. **Our Option to Terminate This Certificate:** We may terminate this Certificate for any of the following reasons:
    A. An Enrollee's intentional misrepresentation of material fact or fraud committed by the Enrollee in connection with any Claim for Benefits filed under this Certificate;
    B. Upon 30 days advance written notice to an Enrollee if he or she persistently fails to cooperate in good faith with the administration of coverage under this Certificate or persistently refuses to comply with treatment plans prescribed by a physician and approved by us;
    C. An Enrollee's coverage for failure to pay any applicable Cost Sharing Amount required under this Certificate upon 30 days advance written notice to such Enrollee unless default in payment is cured within such 30-day period;
    D. Upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's QualChoice identification card or if the Enrollee otherwise cooperates in the unauthorized use of the Enrollee's identification card or Benefits;
    E. Each Enrollee represents all statements made in his or her application for membership, and any applications for membership of dependents, are true to the best of his or her knowledge and belief. If an Enrollee performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, we may void his or her enrollment under this Certificate and the enrollment of his or her covered spouse and dependents. No statement made, for obtaining coverage, will void coverage unless the statement is written in the application and you, the Certificate Holder, signs it;
    F. Failure of an Enrollee to provide information necessary for QualChoice to comply with applicable law, including, but not limited to, the Enrollee's social security number or other government issued identification number;
    G. An Enrollee becomes eligible to enroll in a group health plan or government run health plan and all pre-existing conditions are covered under such group health plan or government run health plan; or
    H. Failure to respond to a request for Recovery of Overpayment in accordance with the provisions of Section 10.8.

    QualChoice will notify the affected Enrollee of a decision to terminate the Enrollee's coverage pursuant to the requirements of applicable law. If QualChoice terminates the coverage of an Enrollee, QualChoice shall have no further liability under this Certificate.
7. **Enrollees on Military Leave:** Enrollees (or an Enrollee's Covered Dependent) called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights apply to covered Enrollees and their Covered Dependents immediately before leaving for military service. The following applies to this election:
    A. The maximum period of coverage of a person under such an election shall be the lesser of:
        1. The 24 month period beginning on the date on which the person's absence begins; or
        2. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
    B. A person who elects to continue health plan coverage must pay up to 102% of the full contribution, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

C. An exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed services.

8. **Hospital Confinement at Time of Termination**: If an Enrollee is facility confined on the date coverage under this Certificate terminates, coverage for such hospitalization will be determined according to the following criteria:
   A. If the Enrollee replaces this Certificate with other coverage, coverage for the Enrollee will continue until facility discharge or Benefits under this Certificate are exhausted, whichever occurs first;
   B. If the Enrollee **does not** replace this Certificate with other coverage, coverage for the Enrollee will cease on the effective date of termination; or
   C. If termination is a result of rescission of coverage by QualChoice, coverage ends on the effective date of such rescission.

   If the hospitalized Enrollee is the Certificate Holder, coverage for any Covered Dependents of this Enrollee ends on the effective date of termination.

6. COORDINATION OF BENEFITS

You and your family members may have coverage under more than one health plan. This Certificate contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1 How COB Works

The order of benefit determination rules govern the order in which each health plan will pay a claim for benefits. The health plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another health plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all health plans do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2 Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary plan coverage:

1. If a health plan does not have a COB provision, that plan is primary.
2. The health plan covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health plan that covers the person as a dependent is secondary.
3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health plan the order of benefits is determined as follows:

   A. For a child whose parents are married or are living together, whether or not they have ever been married:

      (1) The health plan of the parent whose birthday falls earlier in the calendar year is primary; or

      (2) If both parents have the same birthday, the health plan that has covered the parent the longest is primary.

   B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      (1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);

(2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) Plan of the custodial parent;

(b) Plan of the custodial parent's new spouse (if remarried);

(c) Plan of the non-custodial parent; and then

(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health plan of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The health plan covering that same person as a retired or laid-off employee is secondary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health plan, the health plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health plan does not have this rule, and as a result, the health plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

7. The health plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health plan that covered the person the shorter period of time is secondary.

8. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health plans. In addition, this Certificate will not pay more than it would have paid had it been primary.

6.3 Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan covering the Enrollee. This means an expense or service not covered by any plan covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans cover you and compute their benefit payments based on that plan's maximum allowable payment, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans and the Allowable Expense is determined by more than one method, the primary plan's payment arrangement shall be the Allowable Expense for all plans.

6.4 Reduction of Benefits

When this Certificate is secondary, we will reduce our benefits so that the total benefits paid or provided by all plans are not more than one hundred percent (100%) of the total Allowable Expense of the primary plan.

A. In determining the amount to be paid for any claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary plan. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total Benefits paid or provided by all health plans for the claim do not exceed the total Allowable Expense of the primary plan for that claim.
B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.
C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5 Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Certificate and other health plans. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Certificate and other health plans covering the person claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under this Certificate. If it does, QualChoice may pay that amount to the other plan that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7 Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8 Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by a group health plan that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary plan for those services and expenses associated with that hospital admission. As the primary plan, that group health plan will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

7. Complaints and Appeals

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of Certificate language, and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and

binding on the Enrollee and this Certificate. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

7.1 Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Certificate. Our Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request a Level I Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 9.3 below. An "appeal" must be initiated and conducted as described in Section 9.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Department at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:
   QualChoice
   Attention: Appeals and Grievance Coordinator
   P. O. Box 25610
   Little Rock, Arkansas 72221-5610
4. **Complaint Resolution:** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

7.2 Types of Requests and Claims

1. **Pre-Service Claim:** A Pre-Service Claim is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Certificate.
2. **Post-Service Claims:** Post-Service Claims are those claims for services that have already been received by the Enrollee.
3. **Urgent Care Claim:** An Urgent Care Claim is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:
   A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or
   B. Life, health or ability to regain maximum function could be seriously jeopardized.
4. **Concurrent Care Claim**: A Concurrent Care Claim is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.
6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

7.3 Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Level I Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Claim, Concurrent Care Claim or Urgent Care Claim) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 9. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator
   P.O. Box 25610
   Little Rock, AR 72221-5610

2. **Appeal of Pre-Service Claim and Concurrent Care Claim**
   A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee, and respond as soon as possible, but not later than fifteen (15) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
   B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
   C. **Initiating a Pre-Service or Concurrent Care Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing to our Complaint and Appeals Coordinator at the address listed in Subparagraph 1 above.
   D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider have the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within fifteen (15) calendar days of the Committee's hearing.
   E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within fifteen (15) calendar days from the receipt of the appeal.
   F. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Claim or Concurrent Care Claim will be treated as an appeal of an Urgent Care Claim as described in Section 9.3 below subject to the request meeting the criteria for an Urgent Care Claim.

3. **Appeal of Post-Service Claims**
   A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer, will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee and respond with a decision as soon as possible, but not later than thirty (30) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the

decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **Initiating a Post Service Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing or facsimile to our Complaint and Appeals Coordinator at the address or fax number listed in Subparagraph 1 above.

D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within thirty (30) calendar days of the Committee's hearing.

E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within thirty (30) calendar days from the receipt of the appeal.

F. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Claim**

A. **Initiating a Level I Appeal and Level II Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413. An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

B. **Level I Appeal and Level II Appeal.** An appeal of an Urgent Care Claim will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review. A medical director different than the one that made the Level I Appeal decision will make the Level II Appeal decision.

7.4 Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Claim as defined in Section 9.2 above can initially be submitted orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Claim appeal even though investigation will have begun.
2. **Right to Information of Enrollee:** We shall provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:

A. Were relied upon in making the benefit determination;

B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
C. Demonstrate compliance with the terms of the Certificate; and
D. Constitute a statement of policy or guidance with respect to the Certificate concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Claim or Concurrent Care Claim, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the appeal do not accompany the appeal of a Medical Issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

7.5 Conduct of Appeals

An appeal is conducted following the procedures below:

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.
2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by QualChoice with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

7.6 Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

7.7 Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.
2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.
3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:
    A. An individual designated by the Enrollee in writing in a form approved by us;
    B. The treating provider, if it is a Pre-Service Claim, a Concurrent Care Claim, or an Urgent Care Claim, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
    C. A person holding the Enrollee's durable power of attorney;
    D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
    E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.
4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.
5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

    If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Claim or Concurrent Care Claim, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

7.8 External Medical Review

After you have exhausted your Level I and Level II appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Claim, please contact QualChoice's Appeal Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in the Certificate, an express limitation in the Certificate, dollar limits under the Certificate, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on both you and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this section. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 10 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if you have an injury or illness caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for your Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If you receive payment from a third party or any other insurer for the cost of Covered Services, you are obligated to reimburse us. You may reduce such reimbursement by our pro rata share of reasonable attorney's fees and costs you incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 10. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance as we may reasonably require to fully enforcing the terms of this Section 10. You agree to take no action prejudicing our rights and interests under this Section 10.

9. PRE-EXISTING CONDITIONS

Except as otherwise provided in Subparagraph 9.2 below, ~~N~~no Benefits for services of any kind are provided under this Certificate for treatment of an Enrollee's Pre-existing Condition (as defined in the

Section 11) until the Enrollee has had continuous coverage under the previous group policy and this Certificate combined for a period of 12 months from an Enrollee's effective date of coverage under the prior employer group policy. This 12-month period is referred to as the "pre-existing period". If the Enrollee submitted an application for coverage during their initial Waiting Period under the prior employer group policy, the pre-existing period begins on the first day of the Waiting Period. If the Enrollee did not apply for coverage within the Waiting Period, the pre-existing period begins on the Enrollee's original effective date under the prior employer group policy.

9.1 Periods of Creditable Coverage

Periods of Creditable Coverage (as defined in applicable law and regulations) will reduce the Pre-existing Condition exclusion period. For purposes of this Certificate, Creditable Coverage includes the coverage an Enrollee had under the prior employer group policy. The notification an Enrollee receives from us sets out the Enrollee's Pre-existing Condition period as calculated by us. In reaching this determination, we consider Certificates of Creditable Coverage provided by the Enrollee's prior health plans and health insurers as well as information otherwise available to us.

Failure to cooperate fully shall constitute grounds for affirming any original Pre-existing Condition exclusion period determination, and denying Claims on that basis.

9.2 Applicability of Pre-existing Exclusion

This Pre-existing Condition exclusion is not applicable to:

1. Pregnancy if you or your enrolled spouse is pregnant as of the effective date of this Certificate; or
2. An Enrollee under the age of 19.

9.3 Request for Reconsideration of Pre-existing Condition Limitation Period Determination

How to request a reconsideration of a Pre-existing Condition Limitation Period Determination:

1. If an Enrollee disagrees with the Pre-existing Condition limitation period calculated by us, the Enrollee can ask for a reconsideration of this determination by sending a written request to:

   Enrollment Department
   QualChoice
   P.O. Box 25610,
   Little Rock, AR 72221-5610

2. An Enrollee's request for reconsideration must include a written statement of the correct period of time the Enrollee had Creditable Coverage and relevant evidence to corroborate the Enrollee's statement. Relevant evidence can include Certificate(s) of Creditable Coverage issued by prior health plans, explanation of benefits, claims or other correspondence from a health plan indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a benefit certificate, or the telephone number of the Member's prior heath plan.
3. By requesting reconsideration of the determination of a Pre-existing Condition limitation period, the Enrollee agrees to cooperate with efforts to verify prior coverage. Cooperation includes, but is not limited to, providing written authorization to request a certificate on the Enrollee's behalf from prior health plan(s) and insurer(s), providing information about the Enrollee's prior health plan(s) and insurer(s), such as telephone numbers and addresses, and assisting the efforts to determine the validity of the corroborating relevant evidence.
4. We will make our final determination of an Enrollee's Pre-existing Condition limitation period within a reasonable period of time after it receives the Enrollee's written request for reconsideration.
5. Appeals from a denial of a Claim based on the Pre-existing Condition exclusion (as distinguished from appeals concerning the calculation of the Pre-existing Condition limitation period) should follow the general appeal procedures outlined in Section 9.

10. GENERAL PROVISIONS

10.1 Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under this Certificate. If we do so, we will give thirty (30) days written notice to you and the change will go into effect on the date fixed in the notice.

10.2 Assignment

You cannot assign any Benefits or monies due under this Certificate to any person, corporation, organization or other entity. Any assignment by you will be void and have no effect. Assignment means the transfer of your right to the Benefits provided under this Certificate.

10.3 Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. Notice to us must be in writing and mailed to our offices at:

QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

10.4 Your Medical Records

We may need to obtain copies of your medical records from any of your treating providers. This may be necessary to properly administer your Benefits. You, or your legal representative, agree to sign an appropriate authorization for release of medical records upon our request. If you elect not to consent to the release of medical records, we may be unable to properly administer your coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

10.5 Request for Certificate of Creditable Coverage

You may request from us at any time a Certificate of Creditable Coverage by contacting our Customer Service Department.

10.6 Notice of Claim

We must receive your Claim for Benefits within no more than 12 months from the date you receive the service. Failure to meet this requirement will result in payment denial.

10.7 Who Receives Payment Under This Certificate

We will make payments under this Certificate directly to the Network Providers providing care.

10.8 Recovery of Overpayments

On occasion, an incorrect payment may be made to you. Reasons for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem to you in writing. You must return to us within 60 days the amount of the mistaken payment. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

10.9 Confidentiality

Medical records and other information concerning your care we receive from providers are confidential. We will use such information only to administer your coverage. We will only disclose such information as required to coordinate Benefits or assure continuity of care. Other disclosures require your written consent. See your Notice of Privacy Practices for a more detailed description of your privacy rights and duties.

10.10 Complaint and Appeals

You are entitled to have any complaints heard by us. We are obligated to hear and resolve such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures for complaints and appeals set forth in Section 9 will be followed.

10.11 Right to Develop Policies and Guidelines
We reserve the right to develop or adopt policies and guidelines for the administration of Benefits under this Certificate. These policies and guidelines will be interpretive only and will not be contrary to any terms of this Certificate. If you have a question about the policies or guidelines used to apply to a particular Benefit, you may contact us or visit our website at www.qualchoice.com for further information.

10.12 Limitation on Benefit of This Certificate
No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Certificate. The covenants, undertakings, and agreements set forth in this Certificate shall be solely for the benefit of our Enrollees and us.

10.13 Applicable Law
This Certificate, the rights and obligations of our employees and us under this Certificate, and any claims or disputes relating thereto, shall be governed by and construed in accordance with Federal and Arkansas law.

10.14 Headings
Section and subsection headings contained in this Certificate are inserted for convenience of reference only. They shall not be deemed to be part of this Certificate for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

10.15 Pronouns
All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

10.16 Severability
If any part of any provision of this Certificate or any document or writing given pursuant to or in connection with this Certificate shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Certificate.

10.17 Waiver
The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Certificate shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Certificate or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

11. DEFINITIONS
There are other definitions, usually capitalized, contained in various sections throughout this Certificate. The capitalized words or terms used in this Certificate and are not otherwise defined have the meanings set forth below:

11.1 **"Accidental Injury"** means a bodily injury (other than intentionally self-inflicted injury) happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent of disease or bodily infirmity. Accidental Injury to teeth does not include any damage caused by chewing or biting any object.

11.2 **"Benefits"** means reimbursement or payments for health care available to Enrollees covered under this Certificate.

11.3 **"Benefits Summary"** means a document containing specific information relating to your coverage and Cost Sharing Amounts under this Certificate. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum benefits as well as visit and day maximums for limited services.

11.4 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

11.5 **"Certificate"** means this conversion medical benefits policy through which Benefits are provided, in whole or in part, as reflected in this Certificate.

11.6. **"Certificate Holder"** means you, the person to whom this Certificate is issued.

11.7 **"Child"** means the Certificate Holder's natural child, legally adopted child, child for whom the Certificate Holder is the legal guardian, or stepchild. "Child" also includes a child for whom the Certificate Holder is the adoptive parent during the Waiting Period prior to completing the adoption. Foster children are not included in the definition of "Child".

11.8 **"Claim for Benefits" or "Claim"** means (i) a request for payment or prior approval (when required under the Certificate) for a service, supply, medication, equipment or treatment covered by the Certificate, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee's authorized representative, and (iii) is submitted consistent with QualChoice's standard claim filing policies and procedures (copies of which are available on request).

11.9 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge you must pay toward the cost of certain Covered Services. Those Covered Services subject to the application of Coinsurance are identified in your Benefits Summary. Coinsurance is subject to an annual maximum limit.

11.10 **"Complication of Pregnancy"** means a condition requiring facility confinement, when the pregnancy is not terminated, the diagnosis of which is unrelated to the pregnancy but causes the mother's health to be adversely affected. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity which threaten the mother's health or life.

The following will also be considered a Complication of Pregnancy:

1. A c-section occurring after failure of a trial of labor;
2. An emergency c-section required because of fetal or maternal distress during labor;
3. An ectopic pregnancy which is terminated;
4. A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and
5. A non-scheduled c-section.

11.11 **"Co-payment"** means a fixed dollar amount you must pay each time you receive a particular Covered Service to which a Co-payment applies.

11.12 **"Cost Sharing Amount"** means an amount you are required to pay each time you receive a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in your Benefits Summary.

11.13 **"Covered Dependent"** means any member of the Certificate Holder's family who meets the eligibility requirements of Section 5, who is enrolled in the Certificate, and for whom we have received premium.

11.14 **"Covered Service(s)"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Certificate. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the

definition of "Medically Necessary" in this section and the other qualifications set forth in Section 3.

11.15 **"Custodial Care"** means provision of routine care that is primarily for meeting personal needs, including assistance with activities of daily living.

11.16 **"Deductible"** means a certain fixed dollar amount you must incur before we begin to pay for the cost of Covered Services provided to you during each Calendar Year. Each Enrollee must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.

11.17 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

11.18 **"Enrollee"** means a Certificate Holder and any spouse of a Certificate Holder or dependents of the Certificate Holder or of the Certificate Holder's spouse covered under this Certificate.

11.19 **"Enrollment Application"** means the form to be accurately completed by prospective Certificate Holders when they apply for enrollment.

11.20 **"High Dose Chemotherapy"** means Chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., granulocyte, colony-stimulating factor, granulocyte-macrophage colony-stimulating factor, reinfusion of stem cells, reinfusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any Enrollee who received this High Dose Chemotherapy, to prevent life threatening complications of the chemotherapy on the Enrollee's own blood cells.

11.21 **"Injectible Prescription Medications"** means any injectible pharmaceutical that has been approved by the Food and Drug Administration.

11.22 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits under this Certificate are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much your health care provider may bill for a given service, the Benefits under this Certificate will be limited by the Maximum Allowable Charge we establish. If you use a QualChoice Network Provider and QualChoice is the primary payor, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, **if you use an Out-of-Network Provider you will be responsible for all amounts billed**.

11.23 **"Medical Advisory Committee"** means an internal committee composed of practicing physicians selected by QualChoice from the Arkansas medical community.

11.24 **"Medical Policy" or "Medical Policies"** means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit certificate or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical

Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

11.25 **"Medically Necessary" or "Medical Necessity"** means a Covered Service, which in the opinion of our medical personnel:

A. Provides for the diagnosis or treatment of the Enrollee's covered medical condition;
B. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's illness, injury or medical condition in relation to any overall medical/health conditions;
C. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
D. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
E. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

11.26 **"Mental Health or Substance Use Disorder"** means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & Statistical Manual of Mental Diseases of the American Psychiatric Association (DSM) classification.

11.27 **"Network Facility"** means a hospital facility or other facility (e.g., hospice, ambulatory surgery center, etc.) that has entered into an agreement with us to make Covered Services available to Enrollees.

11.28 **"Network Primary Care Physician"** means a physician who has entered into an agreement with us regarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilized by an Enrollee as his or her primary care physician. The following will be considered to be a primary care physician: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

11.29 **"Network Provider"** means a Network Primary Care Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

11.30 **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with us regarding, among other things, willingness to provide specialty Covered Services to Enrollees and who may be utilized by an Enrollee as his or her specialty physician. The following will not be considered to be a specialist: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

11.31 **"Out-of-Network Provider"** means a physician, facility or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees. Regardless of any other provision in this Certificate, the extent of QualChoice's coverage for services provided by an Out-of-Network Provider is as set forth in your Benefits Summary.

11.32 **"Out-of-Pocket Limit"** means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

11.33 **"Pre-existing Condition"** means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on (1) the Member's effective date with the Certificate or (2) the first day of their Waiting Period, as applicable. The period is calculated by counting back from the first day of the Waiting Period, rather than from the Member's actual effective date. If the Member does not apply within the

Waiting Period, the 6-month period is calculated by counting back from the Member's effective date of coverage.

Notwithstanding the definition above, with respect ONLY to an Enrollee who is under nineteen (19) years of age, "Pre-existing Condition" means a condition that was present before the effective date of coverage, or if coverage is denied, the date of the denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition can be identified through information relating to health status before the Enrollee's effective date of coverage or if coverage is denied, the date of the denial, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the Enrollee, or review of medical records relating to the pre-enrollment period.

Moreover, the definition above does not include an Enrollee's pregnancy in existence on the effective date of this Certificate.

11.34 **"Referral"** means a specific written approval from us that an Enrollee seeks for additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Certificate. We issue Referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you are completed during the appropriate period. There will be no coverage for services rendered outside the approved period.

11.35 **"Service Area"** means the geographical area in which we are licensed by the State of Arkansas to conduct business.

11.36 **"Waiting Period"** means the period from your date of hire until the date you were first eligible for coverage under your employer group policy.

Michael E. Stock, President & CEO

QCA Health Plan, Inc.

The QualChoice Building

12615 Chenal Parkway, Suite 300

Little Rock, AR 72211

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
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TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:

Jim Couch on 07/20/2011 03:06 PM

Last Edited By:

Rosalind Minor

Submitted On:

07/28/2011 01:18 PM

Subject:

Redlined compare of current EOC with Conversion EOC

Comments:

I am hoping that the attached redlined comparison of the currently approved group EOC with the proposed conversion EOC will help you with your review.

Point of Service (POS)

CONVERSION EVIDENCE OF COVERAGE CERTIFICATE

Attached is the Benefits Summary indicating name, benefits, Out-of-Pocket Limit amount~~, group number, identification number~~, type of coverage, Preexisting Condition exclusion period, and effective date.

IMPORTANT NOTICE

COVERED SERVICES RECEIVED FROM AN OUT-OF-~~-~~NETWORK PROVIDER, EXCEPT IN CERTAIN VERY LIMITED CIRCUMSTANCES~~,~~ AS SET FORTH IN YOUR BENEFITS SUMMARY ARE ~~PAID AT A RATE LESS THAN SIMILAR~~NOT COVERED ~~SERVICES RECEIVED FROM A NETWORK PROVIDER.~~ REFER TO YOUR BENEFITS SUMMARY.

THIS COVERAGE CONTAINS A PREEXISTING CONDITION LIMITATION. REFER TO THE BENEFITS SUMMARY.

The benefits in this Certificate do not necessarily equal or match those benefits provided in your previous group policy.

Underwritten by:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300

Little Rock, Arkansas 72211
www.qualchoice.com

IMPORTANT QUALCHOICE CONTACT INFORMATION

QualChoice is committed to providing better customer support. That includes making it easy for you to contact us. You are always welcome to call us with any questions or concerns.

Website Address:

www.qualchoice.com

Our Customer Service Department can be reached:

Toll Free at (800) 235-7111

Locally at (501) 228-7111

Our QCARE Coaches can be reached:

Toll Free at (888) 795-6810

Our "Ask a Nurse" assistance line can be reached:

Toll Free at (866) 232-0447

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1. INTRODUCTION TO YOUR CERTIFICATE

1.1. Certificate ~~is Part of Group Master Contract~~

QCA Health Plan, Inc. Inc. ("QualChoice" also referred to as "us", "we" or "our") is a licensed Health Maintenance Organization. QualChoice has a certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone number is (501) 228-7111 or toll free (800) 235-7111.

This is your Evidence of Coverage Certificate (the "Certificate") for health care Benefits with us. This Certificate is ~~part of the Group Master Contract that is~~ a legal document between QCA Health Plan, Inc.~~–~~ and ~~your Employer Group~~you to provide Covered Services subject to the terms, conditions, exclusions and limitations included herein.

1.2. Changes to This Certificate

We may from time to time modify this Certificate through a "Rider" and/or "Amendment" that may change certain provisions of this Certificate. When this happens we will send you a new Certificate, Rider or Amendment.

1.3. Key Information

For purposes of this Certificate, "you" or "your" means the Certificate Holder ~~(i.e., the Employee).~~

Only we have the right to change, interpret, modify, withdraw or add Benefits, or terminate ~~the group~~this contract, as permitted by law, without your approval.

On its effective date, this Certificate replaces and overrules any certificate that we may have previously issued to you. This Certificate will in turn be overruled by any certificate we issue to you in the future.

Your coverage under this Certificate begins at 12:01 a.m. on the effective date ~~determined by your Employer Group and us in~~, which is the ~~Group Master Contract. Coverage will end at 12:00 midnight in~~day following the ~~time zone~~termination of ~~the Employer Group's location.~~your coverage under the employer group policy. We will continue your coverage unless and until ~~your Employer Group~~you or we terminate it for any of the reasons described in this Certificate. ~~Your Employer Group and we~~We determine your eligibility for Benefits under ~~the Plan and~~ this Certificate.

This Certificate and Benefits Summary describe your Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The Benefits Summary provided to you is an integral part of this Certificate. In the event this Certificate and the Benefits Summary conflict, the Benefits Summary will control. You should locate and familiarize yourself with the Benefits Summary.

This Certificate describes some special procedures with which you must comply.

~~We are delivering the Group Master Contract in the State of Arkansas. The Group Master Contract and this Certificate are governed by ERISA unless the Employer Group is not an employee welfare benefit plan as defined in ERISA.~~ To the extent that state law applies, the laws of the State of Arkansas shall govern ~~the Group Master Contract and~~ this Certificate.

We have capitalized certain words in this Certificate. Those words have special meanings and, unless defined otherwise elsewhere, are defined in Section ~~13~~11, "Definitions".

2. HOW THIS PLAN WORKS

This Certificate provides you with a flexible choice in selecting options in obtaining health care services and how your choice may financially impact you. We encourage you to utilize a Network Primary Care Physician to assist in the coordination of your health care services under this Certificate. The utilization of a Network Primary Care Physician is a matter you control and you are not required to notify us of your Network Primary Care Physician relationship. You are always encouraged to seek care directly from a Network Primary Care Physician first. You may also seek care with any Network Physician or Provider under this Plan without a Referral. ~~You have the freedom to select either In-Network Benefits or Out-of-~~

~~Network Benefits (as described below) each time you seek care.~~ Consult your Benefits Summary to identify Covered Services and Cost Sharing amounts ~~for each choice~~.

2.1 In-Network Benefits

~~In-Network Benefits are generally paid at a higher level than Out-of-Network Benefits.~~ In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider or at a Network Facility; or
2. Emergency health services meeting the QualChoice payment guidelines.

Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and meets either of these requirements will be processed as an In-Network Benefit. Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and does not meet either of these requirements will ~~be processed as an Out-of-Network Benefit~~not be covered.

You should validate the status of a Network Provider by accessing the on-line directory at any time or calling Customer Service during normal business hours.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in your Benefits Summary.

You may seek Covered Services from any Network Primary Care Physician or from other Network Physicians without a Referral. Coverage for services in the office is at the primary care physician benefit level when you seek Covered Services directly from any Network Primary Care Physician. Coverage for services in the office is at the specialist benefit level when you seek Covered Services from any other Network Physician. You should validate the status of a Network Provider by calling Customer Service or accessing the on-line provider directory. Please refer to your Benefits Summary for details.

2.2 Out-of-Network Benefits

~~You may seek Covered Services directly from a physician or other provider who is not a Network Provider. Services~~As described in your Benefits Summary, services provided by an Out-of-Network Provider ~~will be~~are not covered ~~and reimbursed under~~unless otherwise stated in your ~~Out-of-Network~~ Benefits Summary or unless prior authorization for coverage as an In-Network Benefit is received from us. ~~The~~Any amounts ~~allowed~~that QualChoice allows for Covered Services ~~accessed under your~~provided by an Out-of-Network ~~Benefits~~Provider will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary ~~and Section 2.5~~ for details:

1. ~~**Plan**~~**Certificate Provision:** The Benefits Summary or this Certificate specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this ~~Plan~~Certificate, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Continuity of Care, Pregnancy, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage you were receiving obstetrical care from an Out-of-Network Provider for a pregnancy covered under the terms of this Certificate, that you were in the third trimester of your pregnancy on the effective date of your coverage, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider.

If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits;

5. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;
6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the ~~Plan~~Certificate, that you were in the third trimester of your pregnancy on the date that the Provider left the PPO, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing QualChoice ~~Life and Health Insurance Company, Inc.,~~ Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3 Network Provider Participation

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at an In-Network Benefit level. You may search the directory on our website at www.qualchoice.com. Because contractual agreements can change, you should verify that a physician or provider is a Network Provider before you seek care.

We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if your Covered Services for that condition are approved by us prior to receiving the service.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A referral, whether written or oral, by a Network Provider to an ~~-~~Out-of-Network Provider; or

2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Provider to provide and coordinate all future Covered Services. If you do not make a change to a single Network Provider within 31 days of the date we notify you, we will assign a single Network Provider to you. ~~If you fail to use the assigned Network Provider, Covered Services will be paid as an Out-of-Network Benefit.~~

2.4 Cost Sharing Requirements

You must share in the cost of your Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult your Benefits Summary to determine the amounts of your payments under these Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill you for the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all ~~applicable Co-payments, Coinsurance and Deductible amounts, plus any difference between the total amount of billed charges for services and the Maximum Allowable Charge.~~charges. **These additional charges could amount to thousands of dollars in additional out-of-pocket expenses for which you are responsible.**

1. **Deductible:** The Deductible is a certain fixed dollar amount per Calendar Year, per person as set forth in your Benefits Summary.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time you receive a Covered Service to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket Limits for each Enrollee or family. Please see your Benefits Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of the Maximum Allowable Charge for the cost of Covered Services you must pay. Coinsurance payments are in addition to Deductibles or Co-payments. Your Benefits Summary contains your Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided to you.
4. **Limits on Your Out-of-Pocket Payments:** You will no longer have to pay Coinsurance for the remainder of the Calendar Year after you have met the Out-of-Pocket Limit during the Calendar Year. Your Benefits Summary lists your Out-of-Pocket Limit for Coinsurance. Coinsurance is the only amount that will apply towards your Out-of-Pocket Limit. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are your responsibility and do not count toward meeting the Out-of-Pocket Limit. Once your Out-of-Pocket Limit has been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge ~~for services provided by an Out-of-Network Provider~~.

~~2.5 Member Financial Responsibility Comparison~~

~~The following table provides an illustration of the cost you will pay for a typical in-patient facility stay utilizing your In-Network Benefits compared to your Out-of-Network Benefits.~~

	~~In-Network~~	~~Out-of-Network~~
~~Hospital Billed Charges~~	~~$50,000~~	~~$50,000~~
~~Contractual Discount~~	~~-25,000~~	~~N/A~~
~~Maximum Allowable Charge~~	~~25,000~~	~~23,000~~
~~Co-Payment Paid by You~~	~~-200~~	~~-200~~
~~Deductible Paid by You~~	~~-500~~	~~-1,000~~
~~Coinsurance Paid by You~~	~~-4,860~~	~~-8,720~~
~~QualChoice Total Payment~~	~~***$19,440***~~	~~***$13,080***~~
~~Your Total Financial Responsibility:~~		
~~Co-Payment~~	~~$ 200~~	~~$ 200~~
~~Deductible~~	~~500~~	~~1,000~~
~~Coinsurance~~	~~4,860~~	~~8,720~~

~~Difference Between Maximum Allowable Charge and Billed Charges~~	~~0~~	~~27,000~~
~~Your Total Financial Responsibility~~	***~~$5,560~~***	***~~$36,920~~***

~~2.6~~

2.5 Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Certificate, and regardless of any other communications or materials you may receive in connection with your ~~Plan~~Certificate, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in ~~Section 13.~~. This standard applies to all sections of this Certificate.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Certificate. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.1.

2.~~7~~6 Exclusion and Limitations

Some services are excluded from coverage and other services have specific coverage limitations.

This Certificate refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

Consult your Benefits Summary, Medical Policies, and Section 4.0 for information on benefit limitations and exclusions.

~~**2.8 Employer Group Coverage**~~

~~Your coverage under this Certificate is part of an Employer Group. To be covered as part of an Employer Group, a Certificate Holder must:~~

1. ~~Work on a permanent and active basis at least 30 hours per week, 48 weeks per year, for your Employer Group covered by this Certificate; and~~
2. ~~Receive ongoing compensation.~~

~~**2.9**~~

2.7 Enrollees Living Outside Service Area For More Than 90 Days

Enrollees that will live, work, or attend school outside the Service Area for more than 90 consecutive days should notify us. The Enrollee uses his/her QualChoice identification card to access Covered Services. Covered Services are processed at the In-Network Benefit level when provided by a QualChoice National Network (QCNN) healthcare provider. Covered Services for services not provided by a QualChoice National Network (QCNN) provider are ~~processed at the Out-of-Network Benefit level. See Section 2.5 above for an example.~~will not be covered.

Enrollees who may use the QCNN for In-Network Benefits are:

1. Dependent students who are attending school outside the Service Area for at least 90 consecutive days, with renewal required annually; or
2. Dependent spouses and children who are living outside the Service Area for at least 90 consecutive days, with renewal required annually~~; or~~.
3. ~~Active full-time employees of an Employer Group based in Arkansas who live outside the Service Area for at least 90 consecutive days; the Employer Group must approve an application for active employees; annual renewal is not required.~~

Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization for those services that we require to be pre-authorized (see Section 2.~~13~~11) to receive Benefits at the In-Network Benefit level when accessing care from the QualChoice National Network (QCNN). It is the responsibility of the Enrollee to obtain the pre-authorization for Covered Services. QCNN providers are not responsible for obtaining a pre-authorization for services.

2.~~10~~8 Coverage While Traveling Out of the Service Area

We cover the cost of Emergency health services an Enrollee incurs while traveling outside of the Service Area, but within the United States. An Enrollee is encouraged to seek services for Emergency health services from health care providers participating in the QualChoice National Network (QCNN) when the Enrollee is out of the Service Area. An Enrollee may limit out-of-pocket expenses for Emergency health services while outside of the Service Area to applicable Cost Sharing Amounts by accessing such care from a QCNN provider.

If care is accessed by an Enrollee from providers not participating in the QCNN, ~~reimbursement for Covered Services will be at the Out-of-Network Benefit level.~~Covered Services received from such providers are not covered except in very limited circumstances as set forth in you Benefits Summary. We will deny coverage for routine and follow up care after Emergency health services unless a Network Provider in Arkansas performs the services.

The QualChoice identification card contains contact information for the QCNN. QCNN providers may be identified by calling the number on the identification card. The Enrollee must present their QualChoice identification card to the servicing provider indicating participation in the QCNN in order to receive this benefit. Submit a Claim for Benefits directly to us for processing. Provisions for Emergency health services as set forth in Section 3.10 must also be followed to receive maximum Benefits.

Dependents who have notified QualChoice that they reside outside the Service Area may access the QCNN providers and facilities for Covered Services at the In-Network benefit level upon prior approval by QualChoice.

2.~~11~~9 General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of this Certificate~~ and the Plan.~~. A final determination of eligibility is made at the time a Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a healthcare care provider, provided within the scope of that healthcare provider's license, and rendered in accordance with professionally recognized standards of care.

During the first year of this Certificate, the Benefits payable under this Certificate shall not exceed those that would have been payable had your Benefits under your former employer's group policy remained in force and effect.

2.~~12~~10 Administration and Interpretation of this Certificate

We have sole and exclusive discretion to interpret the Benefits provided under this Certificate as well as all other provisions, terms, conditions, limitations and exclusions in the Certificate and to make factual determinations related to the Certificate and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Certificate. Subject to applicable law or regulation we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate the Certificate, in our sole discretion, without prior notice to or approval by ~~Employer Groups or Enrollees, whether or not administrative authority has been delegated.~~Enrollees. Changes to this Certificate will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.~~13~~11 Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services must be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

Your responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations for you. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QualChoice National Network (QCNN). QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not responsible for obtaining required pre-authorizations. ~~When you receive care from an Out-of-Network Provider, you are responsible for making sure the provider obtains the required pre-authorizations prior to services being rendered. Out-of-Network Providers must supply the clinical information necessary for us to determine Medical Necessity. We will give no pre-authorization without the necessary clinical information.~~

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if your clinical status has changed sufficiently that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service department. Any of our pre-authorization decisions may be appealed by following the procedures in Section ~~9~~7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.~~14~~12 Utilization Management

We cover Medically Necessary services as described in Section 2.~~6~~5. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.~~15~~13 Case Management

We provide a Case Management program. Case Management assists you to make the best use of your Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, high-risk pregnancy, transplants, oncology and neonatology.

2.~~16~~14 QCARE

QCARE is our population health management program that facilitates access to medical services, and provides tools and self-management assistance to our Enrollees who have chronic medical conditions, such as diabetes, hypertension, and asthma. We work one-on-one with Enrollees to help them understand their illnesses better. We also educate Enrollees on treatment options so that the Enrollee can better manage their health.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this section subject to the General Conditions for Payment specified in Section 2.~~1.19~~, Pre-Authorization of Services described in Section 2.1~~3~~1, and to all other applicable conditions, limitations and exclusions of this Certificate. **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.1 Advanced Diagnostic Imaging

Advanced diagnostic imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of your ~~Plan~~Certificate as set forth in your Benefits Summary; and
2. Pre-authorization is required for these tests. The requirements for pre-authorization are detailed in Section 2.1~~3~~1 must be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2 Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations ~~of the Plan~~ as set forth in this Certificate. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in your Benefits Summary, and the following criteria:

1. When an accident or other medical Emergency occurs, we cover transport to the nearest facility when Emergency services are required;

2. We cover ambulance transportation from one facility to another facility for one of the reasons identified below as long as it is coordinated through the QualChoice Care Management department:
    A. To access equipment or expertise necessary to care for you properly;
    B. To receive a test or service which is not available at the facility where you have been admitted and you return after the test or service is completed;
    C. To transport you from an Out-of-Network Facility to a Network Facility; and
    D. To transport you directly from an acute care setting to an alternate level of care.

3.3 Complications of Pregnancy

Coverage is provided for treatment of Complications of Pregnancy when performed or prescribed by a physician subject to the Deductible and Coinsurance amounts specified in the Benefit Summary.

3.4 Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice prior to services being provided. Benefits are subject to a maximum limit per Enrollee per accident. See your Benefits Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery ("D.D.S.") or a Doctor of Medical Dentistry ("D.M.D."). The damage must be severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

The physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth; or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, or no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

If the Enrollee is under age 15, reimbursement for dental care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of QualChoice, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Enrollee is in force when the treatment is rendered.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position; reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5 Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility; and
2. The situation meets Medical Necessity criteria, and the patient is:

A. A Child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible;
B. A person with a serious mental health condition that prevents use of local anesthesia for the procedure;
C. A person with a serious physical condition making facility care necessary for the safe performance of dental work; or
D. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required (see Section 2.~~13~~11). **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.6 Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis; and
7. Incision of accessory sinuses, salivary glands or ducts.

3.7 Dental – Other

Other dental care and orthodontic services are not covered.

3.8 Diabetes Management

Diabetes self-management training is limited to one program per lifetime per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9 Durable Medical Equipment

Durable Medical Equipment (DME) is equipment primarily and customarily serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used. DME is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person.

You must obtain all DME through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition of and description of coverage for orthotics and prosthetic devices and services are in Sections 3.22 and 3.27 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a Network DME Provider. It is your responsibility to confirm this with your physician. If DME dispensed by your physician is not from a Network DME Provider, you can obtain a prescription from your physician for the DME and contact us to assist in obtaining the equipment. Failure to insure all DME is obtained from a Network DME Provider will result in denial of Benefits.

3.10 Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section ~~13~~11.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section ~~13~~11) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United States, are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling the number at the front of this Certificate.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If in an Emergency an Enrollee goes to an Out-of-Network Facility's emergency room for treatment and the Enrollee is admitted at that Out-of-Network Facility for further care or in-patient treatment, *the Enrollee, a family member or the Facility must notify our Care Management Department once the Enrollee is stabilized, but in no event more than forty-eight (48) hours after initial treatment*. Failure to notify us within the specified forty-eight (48) hour time requirement may result in a denial of Benefits. Upon receipt of such notification, we may either authorize the Enrollee's admission to, or further treatment at, the Out-of-Network Provider hospital, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Provider facility, the admitting physician, and the Enrollee's Network Provider. If the Enrollee stays at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the facility and other ~~providers~~Out-of-Network Providers providing care to you.

3.11 Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

Benefits also include one routine vision exam, including refraction, to detect vision impairment by a Network Provider once every 24 months. Refraction is only covered when provided in conjunction with a routine vision examination.

Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery and for treatment of disease as specified in Section 4.1.

3.12 Family Planning Services

Coverage is provided for ~~the following family planning services:~~

~~1. Oral contraceptives and prescription barrier methods are only covered when an Outpatient Prescription Drug Rider has been purchased through QualChoice; coverage is subject to all of the terms, conditions, limitations, and exclusions of the Prescription Drug Rider; and~~

2. ~~Voluntary~~voluntary sterilizations (vasectomies and tubal ligations) ~~are covered~~ except as excluded in Section 4.1

3.13 Home Health Services

Coverage is available for the following services provided in your home when your medical condition supports the need for such services, the services are ordered by a physician, and are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. (See your Benefits Summary for visit limitation details.)

The following services provided by a licensed home health agency in your home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled care, that is, skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse, is not Custodial Care;
2. Physical, occupational and speech therapy services;
3. Medical supplies provided by the home health agency during the course of approved care; and
4. Home services by a nurse midwife, except home deliveries.

3.14 Home Infusion Therapy

The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment ~~-~~and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.
4. When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15 Hospice Services

Hospice services must be pre-authorized and arranged by a QualChoice Case Manager. Consult your Benefits Summary for applicable Cost Sharing Amounts. Coverage is available for Enrollees with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following hospice services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program, provided the hospice program was pre-authorized by QualChoice:

1. In-patient care in a freestanding hospice, a hospice unit within a facility or skilled nursing facility, or in an acute care facility bed; and
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including, but not limited to, the following:
    A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
    B. Respiratory therapy;
    C. Social services;
    D. Nutritional services;
    E. Laboratory examinations;
    F. Chemotherapy and radiation therapy when required for control of symptoms;

G. Medical supplies; and
H. Medical care provided by a physician.

3.16 Facility – In-patient Care

In-patient facility care Benefits are available for services and supplies received during the facility stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any facility services unless the service is provided to the Enrollee by an employee of the facility, the facility bills for the service, the service is not primarily for convenience, and the facility retains the payment collected for the service.

Hospital in-patient care is also subject to the following conditions:

1. We cover Medically Necessary acute in-patient facility care for the care or treatment of the Enrollee's condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance.
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy.
4. We do not provide Benefits while an Enrollee is waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
   A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
   B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
   C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred; ~~as demonstrated in Section 2.5 above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Facility;~~
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment~~; as demonstrated in Section 2.5. above, this could have a significant financial impact on you if the acute facility the Enrollee is in while waiting to be transferred is an Out-of-Network Provider.~~.
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.~~13~~11. Please call the number listed on your identification card to notify us of the admission.

3.17 Injectible Prescription Medications

Benefits are available for Injectible Prescription Medication(s) received ~~in a physician's office or from a specialty pharmacy provider designated by QualChoice~~only when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility based upon the Maximum Allowable Charge for the Injectible Prescription Medication and subject to the applicable Cost Sharing Amounts specified in your Benefits Summary.~~ Injectible Prescription Medications that Enrollees may have the ability to self-administer may be obtained with direct delivery to the Enrollee's home. Our Case Management staff will assist Enrollees in coordinating this service.~~

3.18 Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19 Maternity Services

The following maternity services are covered ***only*** if you or your enrolled spouse is pregnant as of the effective date of this Certificate:

1. **Fetal Testing:** Amniocentesis or chorionic villus sampling is covered when performed in accordance with recognized standards of care.
2. **In-patient Hospital Stays; Statement of Rights Under the Newborns' and Mothers' Health Protection Act.** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any facility length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

   We will pay for an in-patient facility stay of at least 48 hours for the mother and newborn Child following a normal vaginal delivery. We will pay for an in-patient facility stay of at least 96 hours for the mother and newborn Child following a cesarean section delivery. However, we may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
   Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

   In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact our Customer Service department.
3. **Maternity and Obstetrical Care:** Coverage is provided for Maternity and Obstetrical Care, including routine prenatal care, postnatal care, delivery in an in-patient facility setting, and any related complications. Routine prenatal care includes coverage of only one routine ultrasound usually done between the 16th and 22nd week of pregnancy. If additional ultrasounds are needed due to Medical Necessity, pre-authorization is required. QualChoice provides special prenatal programs designed to benefit you and your baby during pregnancy. These are available at no additional cost and are voluntary. To sign up, you should contact us as early as possible during your pregnancy.
4. **Midwives:** Coverage is provided for services received from a certified nurse midwife, but only if that nurse midwife is a Network Provider and the delivery is done in an in-patient facility setting.
5. **Newborn Care in the Hospital:** A newborn Child of the Certificate Holder or the Certificate Holder's spouse will be covered from the date of birth, including use of newborn nursery and related services, provided the Child's coverage becomes effective on his or her date of birth subject to the requirements of Section 5.0 being met. ~~***However, if such Child is born in an Out-of-Network Provider hospital, the Child's coverage for Covered Services in the first 90 days is limited to the Maximum Allowable Charge. If a Child is born in an Out-of-Network Provider hospital because the Certificate Holder's spouse has other health benefit coverage, or if such Child is an adopted Child born in an Out-of-Network Provider hospital, nursery charges are covered up to the Maximum Allowable Charge.***~~

3.20 Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a Network Physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and

3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds $2,400 per year per person.

The covered amount will be the incurred cost of medical food or low protein modified food products that are in excess of the $2,400 per year per person, subject to the Cost Sharing Amounts specified in your Benefits Summary.

3.21 Medical Supplies

Medical supplies are items that are consumed or reduced with use so that they cannot be repeatedly used, are primarily or customarily used for medical purposes, and are generally not useful in the absence of an illness or injury. Medical supplies do not include medications or implants. Medical supplies are only covered when prescribed by a physician and when Medically Necessary.

The following conditions will also apply to coverage for Medical supplies:

1. Coverage for medical supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for medical supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used; and
3. Coverage for medical supplies is limited to a 31-day supply per month.

3.22 Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.~~13~~11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does ***not*** include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments–, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments–, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.23 Outpatient Services

Outpatient Covered Services are as follows:

1. Outpatient Facility Services: Subject to all of the terms, conditions, limitations and exclusions of this Certificate, Covered Services shall include services provided in a licensed outpatient facility or at a facility outpatient department. Examples include diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for in-patient admission.

2. Outpatient Surgery: Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient facility setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service.

~~If you use an Out-of-Network Facility or ambulatory surgery center, payment from QualChoice will be limited to the Maximum Allowable Charge.~~

We cover Medically Necessary surgical services. We apply multiple surgical procedures reduction when the same provider performs two or more surgical procedures on the same Enrollee within the same operative session.

3.24 Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefits Summary.

3.25 Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com or you may contact our Customer Service department to obtain specific coverage guidelines.

3.26 Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations ~~of the Plan~~ as set forth in this Certificate and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in

addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).

2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;
5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.27 Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.~~13~~11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.28 Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Certificate.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Enrollee;

2. Surgery performed on a child for the correction of a cleft palate or cleft lip, removal of a port-wine stain (**only** on the face), or correction of a congenital abnormality. In order to be covered, such corrective surgery for a congenital defect must be performed when the child is twelve (12) years or younger, unless, in its sole discretion QualChoice determines that due to the complexity of the procedure, such surgery could not be performed prior to the child's twelfth (12^{th}) birthday. Dental care to correct congenital defects is not a covered benefit;
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery;
4. In connection with a mastectomy eligible for coverage under this Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphademas; or
5. Reduction Mammoplasty that meets our criteria for coverage (which you may request to obtain a copy from us) is a Covered Service subject to Deductible and 50% Coinsurance. Pre-authorization is required.

Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. As further explained in Section 4.1, we do not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services.

3.29 Skilled Nursing Facility and In-patient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute in-patient rehabilitation facility when provided immediately after hospitalization in an acute care general facility for a covered illness or injury. Care will be limited to the number of covered days provided by your ~~policy~~Certificate and if Medically Necessary for continued improvement. See your Benefits Summary for details.

3.30 Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy~~ and chiropractic~~, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a facility. Refer to your Benefits Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.31 Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Certificate. Consult your Benefits Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your QualChoice identification card to obtain pre-authorization before your evaluation for transplant and placement on any transplant list***. Once the evaluation is complete, you must obtain an additional pre-authorization for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the ~~Plan~~Certificate as follows:
    A. **Transplant Covered Services:** We will cover any facility, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us**.

B. **Facility Care:** We cover all in-patient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network Facility, we may require Network Providers at a Network Facility to provide some follow-up care.

C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. This coverage applies to the donor whose organ has been selected to be used in the transplantation. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health plan indicating coverage or denial for the donation.) Please refer to your Benefits Summary for Cost Sharing Amounts and lifetime maximums.

3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   - A. Aplastic anemia
   - B. Wiscott-Aldrich syndrome
   - C. Albers-Schonberg syndrome
   - D. Hemoglobinopathy, e.g., Thalassemia major
   - E. Myelodysplastic syndromes – primary and acquired
   - F. Immunodeficiency syndrome
   - G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   - H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   - I. Neuroblastoma, stage III or IV
   - J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   - K. Chronic myelogenous leukemia in the chronic phase
   - L. Multiple myeloma
   - M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse
   - N. Chronic Lymphocytic Leukemia
   - O. Marrow failure, Fanconi's, red cell aplasia
   - P. Amyloidoosis
   - Q. Paroxysmal Nocturnal Hemoglobinuria

   This ~~Plan~~Certificate requires specific donor matches for certain procedures.

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions ~~of the Plan~~as set forth in this Certificate. Cornea transplantation does not require pre-authorization.

IMPORTANT NOTE REGARDING TRANSPLANTATION SERVICES: It is important that you review and understand the benefit limitations for transplant services described in Section 4.2 of this Certificate.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This section describes those exclusions and limitations. One or more of our optional coverage riders may cover some of these items. If ~~your Employer Group has~~you have purchased riders, they will be provided to you in writing. Please refer to your Benefits Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1 Non-Covered Services and Exclusions from Coverage

1. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.
2. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted Child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges. For the purpose of this ~~Plan~~Certificate, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth. Refer to Section 5.~~3~~.1 for information regarding coverage of adopted children.
3. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
4. **Against Medical Advice:** We will not cover any services related to an in-patient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
5. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as the following:
   A. Acupuncture;
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy;
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy; and
   K. Massage Therapy (except as provided for in QualChoice's Medical Policies).
6. **Baby Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
7. **Blood and Blood Donation:** We do not pay for any charges associated with blood donations. We do not pay for procurement, or storage, of donated blood. We do not cover umbilical cord blood banking or blood banking for blood or blood products with unscheduled future use. We do cover the charges for administration of blood and blood products. We do cover blood or blood product banking charges for covered procedures planned in the next 180 days.
8. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
9. **Care Plan Oversight**: Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
10. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
11. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in facilities not licensed as short-term acute care general facility or skilled nursing facilities, for example:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;
    D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis facility;
    E. Infirmaries at camps or schools;
    F. Hospitals for treatment of a Mental Health or Substance Use Disorder;

G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);
H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.29);
I. Extended care, chronic care, or transitional facilities or facilities (except as covered under Section 3.29); or
J. Other facilities and institutions, which do not meet our criteria for short-term acute care general facility or skilled nursing facilities

12. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
13. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year annual treatment limits or lifetime maximums as shown on the Benefits Summary.
14. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
15. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
16. **Chemical Ecology:** Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
17. **Chiropractic Care:** Chiropractic care services are not covered.
~~17.~~18. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
~~18.~~19. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the-counter (without a prescription) are not covered.
~~19.~~20. **Convenience Items or Services:** We will not cover items or services utilized primarily for your convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to, a cot, hot water bottle, telephone, television, television rental charges, whirlpool bath, automobile/van conversion, wheel chair ramp, and home modifications.
~~20.~~21. **Cosmetic or Reconstructive Services**: Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. We will not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services. Procedures or services that change or improve appearance without improving physiological function are also not covered. Procedures or services that correct a physical developmental defect present at the time of birth without improving or restoring physiologic function are considered cosmetic procedures. The fact that an Enrollee may suffer psychological consequences as a result of an injury, sickness or developmental defect present at the time of birth, does not make the service Medically Necessary.
~~21.~~22. **Custodial Care:** We do not cover Custodial Care. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial Care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding, or range of motion exercises. Non-covered Custodial Care may be rendered in a facility, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.
~~22.~~23. **Dental Care:** This ~~Plan~~Certificate does not provide Benefits for dental care. Except as otherwise stated in this Certificate, we do not cover:
A. Treatment of cavities;

B. Tooth extractions;
C. Care of the gums;
D. Care of the bones supporting the teeth;
E. Treatment of periodontal disease;
F. Treatment of dental abscess;
G. Treatment of dentigerous cysts;
H. Removal of soft tissue supporting or surrounding teeth;
I. Orthodontia (including braces);
J. False teeth;
K. Orthognathic surgery; or
L. Any other dental services you may receive, except as specifically set out in your Benefits Summary.

~~23.~~24. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.

~~24.~~25. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.

~~25.~~26. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit, and motor dysfunctions are not covered. Except for an autism screening occurring one time between the ages of 1 and 4, this includes an exclusion for developmental delay associated with autism spectrum disorder.

~~26.~~27. **Dietary and Nutritional Services:** Unless dietary supplies are the sole source of nutrition for the Enrollee (see Section 3.~~20~~21 - Medical Foods), any services or supplies provided for dietary or nutritional services, including, but not limited to, medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a physician or acquired over-the-counter, are not a covered.

~~27.~~28. **Domestic Partners:** We do not provide coverage for domestic partners of the same sex or opposite sex.

~~28.~~29. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.

~~29.~~30. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.

~~30.~~31. **Electronic Consultations:** We do not cover charges for a healthcare provider's consultation by telephone, email, or other electronic communications with you or another healthcare provider.

~~31.~~32. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, are not covered. However, subject to all terms, conditions, exclusion and limitations ~~of the Plan~~ as set forth in this Certificate; coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.

~~32.~~33. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is not covered. However, subject to all terms, conditions, exclusion and limitations ~~of the Plan as set forth~~ in this Certificate, and at the sole determination of QualChoice, coverage may be provided for enhanced external counterpulsation for the treatment of Enrollees with coronary artery disease documented by coronary artery catheterization. Our Medical Policy regarding enhanced external counterpulsation is available on our website www.qualchoice.com or you may contact our customer service department to obtain specific coverage guidelines.

~~33.~~34. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.

~~34.~~35. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under ~~a prescription drug rider or~~ this Certificate, on grounds of excessive use when it is the determination of our medical director that: (1) an Enrollee has exceeded the

dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia, or by the QualChoice Pharmacy & Therapeutics Committee; or (2) an Enrollee has obtained or attempted to obtain the same medication from more than one physician for the same or overlapping periods of time; or (3) the pattern of prescription medication purchases, changes of physicians or pharmacy, or other information indicates an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider, or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use, or activity to evaluate for excessive use.

~~35.~~36. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a physician.

~~36.~~37. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.

~~37.~~38. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including, but not limited to, plantar fasciitis or tennis elbow, is not covered.

~~38.~~39. **First Aid Supplies:** We will not cover over-the-counter first aid supplies.

~~39.~~40. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, non-surgical care of bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations of ~~the Plan as set forth in~~ this Certificate, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.

~~40.~~41. **Foot Orthotics:** Foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

~~41.~~42. **Fraud or Misrepresentation:** Health interventions or health services, including, but not limited to, medications obtained by unauthorized or fraudulent use of an Enrollee's QualChoice identification card or by material misrepresentation as part of your enrollment process or at other times, are not covered.

~~42.~~43. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you and/or the provider did not think there would be insurance when the provider chose not to charge for the care provided.

~~43.~~44. **Gastric Electrical Stimulators:** Gastric electrical stimulators~~, gastric pacemakers,~~ or electrogastrography are not covered.

~~44.~~45. **Government Programs:** We will not pay for Covered Services to the extent Benefits for such services are payable under Medicare or any other federal, state or local government program.

~~45.~~46. **Group Therapy:** Group therapy or group counseling at any time in any setting by any provider is not covered.

46.47. **Hair Loss or Growth:** Wigs, hair transplants, or any medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.

47.48. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered. Cochlear implants are the only exception to this exclusion as specified in Section 4.2(4).

48.49. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.

49.50. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants, and Nonmyeloalative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.31.

50.51. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.

51.52. **Illegal Acts:** Except as required by law, we will not cover health care services resulting from participation in a felony, riot, insurrection, or other illegal act, whether or not convicted.

52.53. **Illegal Uses:** Medications, drugs, or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or accidental injuries from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits are not covered.

53.54. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury, or prostate surgery.

54.55. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered.

55.56. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications, procedures, or other services for treatment of infertility. It does not matter whether the infertility service is diagnostic or therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:

A. Reversal of sterilization;
B. Pre-implantation testing;
C. Surrogate pregnancies;
D. Medical treatment of infertility;
E. Surgical treatment of infertility; and
F. In vitro fertilization

Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying cause of the infertility are detected or treated during such surgery.

56.57. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of ~~the Plan set forth in~~ this Certificate, where the Enrollee is on a cardiac transplant list at a facility where there is an ongoing cardiac transplantation program, the ~~Plan~~Certificate will cover infusion of inotropic agents.

57.58. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars, or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes,

educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.

~~58.~~59. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.

~~59.~~60. **Learning Disabilities:** Services or supplies provided for learning disabilities, for example, reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties, are not covered.

~~60.~~61. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. is not covered.

~~61.~~62. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.

~~62.~~63. **Maintenance Therapy:** We will not cover maintenance therapy for physical therapy, occupational therapy, or speech therapy.

~~63.~~64. **Mammoplasty:** Except as provided in Section 3.28, we do not cover mammoplasty for reasons of augmentation or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.

~~64.~~65. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party such as, but not limited to, an employer, licensing board, recreation council, or school.

~~65.~~66. **Marriage and Relationship Counseling:** Marriage and relationship counseling services are not covered.

~~66.~~67. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms or the preparation or copying of medical records.

~~67.~~68. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services, or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications, counseling, weight maintenance programs, gastric stapling, gastric bypass, or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.

~~68.~~69. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including, but not limited to, a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.

~~69.~~70. **Mental Health or Substance Use Disorder:** ~~Unless a Mental Health Parity Rider, Treatment of Psychiatric Conditions Benefits Rider, and/or Treatment of Substance Abuse Benefits Rider is included with this Certificate, services~~Services of any kind or nature for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse are not covered. Services that are excluded include, but are not limited to:

A. Testing, evaluation, assessment and/or treatment of every diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
B. Hypnotherapy;
C. Treatment of behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
D. Hospitalization for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse;
E. Evaluation of psychosocial factors potentially impacting physical health problems and treatments, including health and behavior assessment procedures used to identify

psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems;

F. Services for treatment of eating disorders are not covered; this exclusion includes treatment for anorexia, bulimia and other eating disorders; and

G. Family counseling in conjunction with an Enrollee's individual crisis therapy.

~~70.~~71. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of an Enrollee's refusal to comply with a physician's or other provider's recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.

~~71.~~72. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.

~~72.~~73. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.

~~73.~~74. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.

~~74.~~75. **Over-the-Counter Medications:** ~~Unless specifically identified in an Outpatient Prescription Drug Rider purchased from QualChoice, medications~~Medications (except insulin) which do not by law require a prescription from a physician are not covered.

~~75.~~76. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.

~~76.~~77. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.

~~77.~~78. **Percutaneous diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.

~~78.~~79. **Percutaneous Kyphoplasty:** Percutaneous kyphoplasty is not covered.

~~79.~~80. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.

~~80.~~81. **Performance Enhancement:** We will not cover medical, surgical, or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic, or recreational performance, including, but not limited to, work hardening programs, back schools, programs of general physical conditioning, athletic trainers, and special or specially modified surgical procedures designed to enhance performance above normal.

~~81.~~82. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.

~~82.~~83. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.

~~83.~~84. **Pre-existing Conditions:** Benefits for the treatment of a Pre-existing Condition are excluded until you have had continuous coverage under your previous group policy and this Certificate for 12 months. This exclusion does not apply to an Enrollee under the age of 19. ~~the earlier of the following:~~

~~A. The date you have had Continuous Creditable Coverage for 12 months; or~~

~~B. The date you have had Continuous Creditable Coverage for 18 months if you are a Late Enrollee.~~

~~This exclusion does not apply to an Enrollee under the age of 19.~~ ~~***You are responsible for providing us with a Certificate of Creditable Coverage from your prior insurance program.***~~

~~84.~~85. **Pre-Implantation Genetic Diagnosis:** We do not cover pre-implantation genetic diagnosis or treatment.

~~85.~~86. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.

87. **Prescription Drugs:** We do not cover medications prescribed for an Enrollee for use on an outpatient basis, that is, medications not dispensed or administered when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility.

~~86.~~88. **Private Duty Nurses:** We will not cover private duty nurses.

~~87.~~89. **Private Room:** We do not cover a private facility room. We will pay the most common charge for semi-private accommodations. If you are charged for a private room, you must pay the difference between the charges for a private room and our payment.

~~88.~~90. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.

~~89.~~91. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.

~~90.~~92. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:

A. Obtaining employment;
B. Maintaining employment;
C. Obtaining insurance;
D. Obtaining professional or other licenses;
E. Engaging in travel;
F. Athletic or recreational activities; or
G. Attending a school, camp, or other program.

~~91.~~93. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.

~~92.~~94. **Rest Cures:** Services or supplies for rest cures are not covered.

~~93.~~95. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.

~~94.~~96. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.

~~95.~~97. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental) meeting the definition of a Mental Health or Substance Abuse Disorder.

~~96.~~98. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.

~~97.~~99. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Certificate as being a Covered Service.

~~98.~~100. **Services Received Outside the United States:** Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of QualChoice.

~~99.~~101. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.

~~100.~~102. **Sexual and Gender Identity Disorders**: Any services related to the treatment of sexual and gender identity disorders are not covered.

~~101.~~103. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome are not covered, except when short stature is caused by laboratory documented growth hormone deficiency.

~~102.~~104. **Sleep Apnea, Portable Studies:** Studies for the diagnosis, assessment, or management of obstructive sleep apnea, not continuously attended by a qualified technician, are not covered.

~~103.~~105. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is included with this Certificate, treatment of caffeine, smoking, or nicotine addiction, smoking cessation prescription medication products, including, but not limited to, nicotine gum and nicotine patches, are not covered.

~~104.~~106. **Snoring:** Devices, procedures, or supplies to treat snoring are not covered.

~~105.~~107. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.

~~106.~~108. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.

~~107.~~109. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Certificate, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical, and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including, but not limited to, the shortening of the mandible or maxillae or the correction of malocclusion.

~~108.~~110. **Thermography:** Thermography, which is the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.

~~109.~~111. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or facility or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Certificate prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Enrollee from the third party, or its insurer. Please refer to Section ~~10~~8 and Section ~~12~~10.8 for further information concerning repayment of Benefits.

~~110.~~112. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.

~~111.~~113. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.

~~112.~~114. **Trans-telephonic Home Spirometry:** Trans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations of ~~the Plan as set forth in~~ this Certificate, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.

~~113.~~115. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for ground or air emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department. Refer to your Benefits Summary for limitations.

~~114.~~116. **Travel, School, Recreation, or Work Related Immunizations:** Except to the extent coverage is specifically provided in this Certificate as a preventive health benefit, we will not cover immunizations to fulfill requirements for international travel, school, recreation, or for work.

~~115.~~117. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.

~~116.~~118. **Vision:** Except as set forth in the Benefits Summary, we will not cover routine eye, services or tests, eyeglasses, contact lenses, and other vision care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes.

~~117.~~119. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglass and contact lenses (except the initial acquisition of one pair within the twelve months following cataract surgery up to $200 for frames and lenses), are not covered.

~~118.~~120. **Vitamins or Supplements:** Vitamins or nutrient supplements~~, except those that are prescription medications on an approved QualChoice Formulary as described in the Outpatient Prescription Drug Rider included with this Certificate and are~~ not available over the counter~~,~~ are not covered. However, subject to all terms, conditions, exclusions and limitations of ~~the Plan set forth in~~ this Certificate, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism as described in Section 3.2~~0~~1 – Medical Foods.

~~119.~~121. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.

~~120.~~122. **Weight Control:** Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.

~~121.~~123. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.

~~122.~~124. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition, or disease arising from your employment. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law.

~~123.~~125. **Wound Treatment:** Blood derived growth factors are not covered.

4.2 Limitations to Benefits

Coverage is available for medical services or care as specified in this Section 4.2 subject to the General Conditions for Payment specified in ~~Section 2.11~~Section 2.9, Pre-Authorization of Services described in Section 2.~~13~~11, and to all other applicable conditions, limitations and exclusions of this Certificate.

1. **Ambulance:** Transportation by ambulance of any kind is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult your Benefits Summary for benefit limitations.
2. **Auditory Brain Stem Implant.** One auditory brain stem implant per lifetime is covered for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone removal of bilateral acoustic tumors.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Cochlear Implants:** Coverage for cochlear implants is subject to a maximum lifetime benefit of $20,000 per Enrollee. Coverage is limited to one cochlear implant device, the surgical procedure, and one speech processor. Reimplantation of the same device is not covered. Pre-authorization is required.
5. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of facility or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
6. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Out-of Network DME is not covered. Please refer to your Benefits Summary for this annual limit.
7. **Genetic Counseling and Testing:** Genetic testing is generally not covered. Genetic testing is often done on blood or tissue samples sent by your physician to a laboratory. *For genetic counseling or testing to be covered, it requires pre-authorization.* Pre-authorization will only

be given in accordance with QualChoice's Medical Policies which require the results of the genetic testing to affect choice of treatment or the outcome of treatment. We will not cover genetic counseling or testing to determine the likelihood of:

A. Developing a disease or condition; or
B. Disease or the presence of a disease in a relative; or
C. Passing an inheritable disease, for example, cystic fibrosis, or congenital abnormality to an offspring.

However, subject to all terms, conditions, exclusions and limitations set out in this Certificate, genetic testing of the products of an amniocentesis to determine the presence of a disease or congenital anomaly in the fetus or genetic testing of an Enrollee's tissue to determine if the Enrollee has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered if the test meets QualChoice's Medical Necessity criteria. Any approved genetic testing must be preceded by genetic counseling.

8. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Contract Year. The home health care visit limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
9. **Hospice Services:** Hospice services are limited to a maximum number of days of coverage per Enrollee. The hospice services day limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
10. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
11. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.
12. **Lifetime Maximum:** Consult your Benefits Summary and this Certificate for various lifetime maximum Benefits per Enrollee.
13. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Physicians and Network Facilities will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
14. **Medical Supplies:** Coverage of medical supplies is limited to a 31-day supply per month.
15. **Newborn Care:** We will cover Newborn Children of the Certificate Holder or spouse from the date of birth provided the Certificate Holder enrolls the newborn within 90 days after the date of birth. ~~If such Child is born in an Out-of-Network Provider hospital, the Child's coverage for Covered Services in the first 90 days is limited to the Maximum Allowable Charge . If a Child is born in an Out-of-Network Provider hospital because the Certificate Holder's spouse has other health benefit coverage, or if such Child is an adopted Child born in an Out-of-Network Provider hospital, nursery charges are covered up to the Maximum Allowable Charge .~~
16. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation, and cardiac rehabilitation~~, and chiropractic~~ services are limited to a maximum number of visits per Enrollee per Contract Year as reflected in your Benefits Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider ~~are limited~~will not be covered as set out in your Benefits Summary.
17. **Prosthetic and Orthotic Devices and Services.** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.
18. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Physicians for personal reasons. In such case, neither we nor any Network Physician or Provider shall have any further responsibility to provide care for the

condition under treatment, unless you later recant the refusal and agree to follow the recommended treatment or procedure.

19. **Shoes and Shoe Inserts:** Custom molded and fitted shoes and shoe inserts are not covered except for an Enrollee with diabetes. Coverage for an Enrollee with diabetes for custom molded and fitted shoes and shoe inserts is subject to the following limitations:
    A. Two (2) pairs of custom molded and fitted shoes per year if the Enrollee is under 18 years of age and one (1) pair of custom molded and fitted shoes for an Enrollee 18 years of age or older; and
    B. Two (2) pairs of custom molded shoe inserts per year.
20. **Transplant Services:** Transplant services are subject to the following benefit maximums and limitations:
    A. Coverage for procurement and testing (per transplant) is limited to the amount reflected in your Benefits Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary ;
    C. We will not cover the transportation and/or lodging costs of the transplant recipient, transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs;
    D. Coverage is limited to no more than the number of transplants per Enrollee per lifetime as reflected in your Benefits Summary. We cover re-transplantation, but a re-transplant is considered a transplant and counts toward the transplant limit;
    E. Expenses for drugs related to avoidance of rejection of a transplanted organ are subject to the lifetime transplant maximum as reflected in your Benefits Summary;
    F. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission, or in complete remission less than two (2) years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis; and
    G. **Transplants that are not pre-authorized by QualChoice Care Management Department are not covered.**

5. ELIGIBILITY CRITERIA

5.1 Who is Eligible for Coverage

~~You must list yourself, the Employee,~~Only you and your dependents who were covered under your original employer group policy on the date of termination of coverage under that employer group policy are eligible for coverage under this Certificate. You must list yourself and any of your eligible dependents you are electing to cover on the Enrollment Application to be eligible for coverage. If you do not list them on the Enrollment Application, they will not be eligible for coverage under this Certificate. You and your dependents must meet all eligibility requirements in this Certificate ~~and as set forth by the Employer Group in the group application and Group Master Contract~~. The following members of your family may be eligible as dependents as long as they were covered under your original employer group policy on the date of termination of coverage under that employer group policy:

1. Your spouse, unless you are divorced or have annulled your marriage. Domestic partners are not eligible for coverage as a dependent under this Certificate.
2. Your Child until s/he becomes twenty-six (26) years of age. However, if your ~~Plan~~prior employer group policy is a grandfathered plan ~~as indicated in your Benefits Summary~~, your

Child nineteen (19) years of age and older but who has not attained the age of twenty-six (26) years is eligible only if s/he is not otherwise eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.

3. Your incapacitated Child may be an eligible dependent. The incapacitated Child must be twenty-six (26) years of age or older and totally disabled due to continuous developmental or physical incapacity. The incapacitated Child must be primarily dependent on you for financial support and you must declare the incapacitated Child as a dependent on your federal income tax returns. The disability leading to mental or physical incapacity must have occurred before the Child reached age twenty-six (26) and while covered under this ~~Plan~~Certificate or other group medical insurance coverage. The Social Security Administration or a physician must medically certify the disability. In addition to this medical certification, we have the unilateral right to determine whether a Child is, and continues to qualify as an incapacitated Child. At any time, we may request a declaration of disability (or like document) supporting such dependent's incapacity and dependency. You must notify us if the incapacity or dependency is removed or terminated. Newly eligible Enrollees may enroll an incapacitated Child provided the disability commenced before the limiting age and a health benefit plan continuously covered the Child as your dependent since before the limiting age. Our determination of eligibility shall be conclusive.

~~4. A Child covered under a Qualified Medical Child Support Order may be an eligible dependent. As required by the Federal Omnibus Budget Reconciliation Act of 1993, your Child who is an alternate recipient under a Qualified Medical Child Support Order has the right to be eligible under this Certificate, upon proper notice to your Employer Group and to us. In the event a court has ordered an employee of the Employer Group without coverage under this Plan to provide coverage for a child, the employee will enroll with the child on the first day of the month following receipt of proper notice by us. We must receive the premium for the employee and the child when due and an Enrollment Application from the Employer Group, a custodial parent of the child, a child support agency having a duty to collect or enforce support of the child, or the child.~~

~~5.~~4. Coverage for a Child whom you have adopted or for whom you have filed a petition for adoption shall begin on the date of the adoption or the date of the filing of the petition for adoption. You must submit an Enrollment Application to us within 60 days after the adoption or the filing of the petition. Coverage will begin subject to payment of all applicable premiums. The coverage shall begin from the moment of birth if the petition for adoption or adoption occurred and you submit the application for coverage to us within 60 days of the birth of the Child. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

~~6. If the armed services of the United States of America activate an Enrollee, the coverage of the Enrollee and any dependents may continue on COBRA for a period of 18 months or under the Uniformed Services Employment Reemployment Rights Act (USERRA). A former Enrollee returning from active military service may enroll in the Plan within 90 days of his or her return to employment provided the Employer Group continues to sponsor the Plan and payment of premium is timely made. We may require a copy of the returning Enrollee's orders terminating the active duty or other proof of the active duty or termination date thereof.~~

Your coverage begins upon the effective date of this Certificate ~~as determined by~~which is the day following your ~~Employer Group.~~termination of your coverage under the group Certificate. You should contact ~~your Employer Group~~our Customer Service Department for information concerning your eligibility requirements and effective date. You will not be eligible to enroll if you do not meet the eligibility rules of this Certificate.

Neither you nor your ~~Employer Group and us. You~~dependent will ~~also not~~ be eligible to enroll if ~~you~~:

1. You have had previous coverage with us terminated for causes described in Section 5.4(~~7~~5) of this Certificate.

2. Such person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program.

3. Such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.

4. Such benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.

5. The benefits provided under subparagraph (2) above for such person, or benefits provided or available under the sources referred to in subparagraphs (3) and (4) above for such person, together with the benefits provided by this Certificate, would result in over-insurance according to our standards as filed with Arkansas Insurance Department, if any.

6. If such person is eligible for Medicare.

Coverage for ~~new members of~~newborn or adopted children in your family begins on the date they meet the eligibility requirements of this Certificate. Coverage for your newborn Child is effective as of the date of birth if you submit an Enrollment Application to us within 90 days of the date of birth of the Child or before the next premium due date, whichever is later. Coverage for your adopted Child is effective as of the date of the adoption if you submit an Enrollment Application to us within 90 days of the date of the adoption of the Child or before the next premium due date, whichever is later.

Coverage, subject to all other terms, conditions, exclusions and limitations of this Certificate, will be extended to an eligible Enrollee who is inpatient in a facility on the effective date of this Certificate. However, consistent with applicable law, if such eligible Enrollee is inpatient in a facility on the effective date of this Certificate and immediately prior to such effective date was covered by ~~another~~a group health plan that provides coverage for facility or medical services or expenses, coverage for benefits under that other group health plan will continue and it will be primarily responsible for those services and expenses associated with that facility admission. As the primary plan, that other group health plan will be responsible for those services and expenses until the end of that facility admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

~~Coverage for your newborn Child is effective as of the date of birth if you submit an Enrollment Application to us within 90 days of the date of birth of the Child or before the next premium due date, whichever is later.~~

If your Covered Dependent gives birth, the newborn grandchild is not eligible for coverage. If you, as the Child's grandparent, adopt or become the legal guardian of the Child, we will cover the Child from the effective date of the adoption or the legal guardianship. ~~If you submit the Enrollment Application for newborn coverage after the 90-day time period, coverage for such newborn Child may only become effective in accordance with the provisions of Section 5.3 below.~~

~~5.2 If You Are Eligible for Medicare~~

~~Your Benefits under this Certificate may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.~~

~~Your Benefits may also be reduced if you are enrolled in a Medicare+Choice (Medicare Part C) plan but fail to follow the rules of that plan. See Section 7 - Medicare Primary Payer for more information about how Medicare may affect your Benefits.~~

~~5.3 Special Enrollment Period~~

~~A special enrollment period applies when one of the conditions listed below occurs. A condition of participation under this Certificate is your agreement to notify us in writing immediately of any changes in status affecting you or your dependents. This can be done by completing an Enrollment Application (which notifies us about changes in eligibility and enrollment) and giving it to your Employer Group who must send the Enrollment Application to us within 30 days (unless specifically provided otherwise below) of the occurrence of one of the following events:~~

1. ~~Marriage and/or divorce;~~
2. ~~Birth and/or death;~~
3. ~~Adoption;~~
4. ~~Addition of a Child through a Qualified Medical Child Support Order;~~
5. ~~Addition of step-children;~~
6. ~~Permanent legal custody of a Child;~~
7. ~~Reinstatement of civilian status of Active Duty Military Personnel;~~
8. ~~Loss of other group health insurance coverage, unless the coverage was terminated for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health plan) or as a result of failure to pay any required contributions toward the cost of coverage on a timely basis; or~~
9. ~~You or your dependent loses Medicaid coverage or coverage under the state children's health insurance program (CHIP, for example, ARKids) because you are no longer eligible, or you or your dependent qualifies for state assistance in paying your employer group medical plan premiums.~~

~~Coverage may only be changed or made to be effective during an Open Enrollment if we do not receive notification within 30 days of the event. We do not permit additions, deletions or changes in coverage more than 30 days after the event. In the event you or your dependent loses Medicaid coverage under the state children's health insurance program (CHIP, for example, ARKids) because of loss of eligibility or become eligible for a state's premium assistance program, you must notify us within 60 days following the date of the event. We allow 90 days for newborns and members reinstated from military active duty.~~

~~5.4~~5.2 Termination of Coverage

Your coverage under this ~~Plan~~Certificate will terminate in certain circumstances. We describe these circumstances below. ~~Refer to Section 8 for information regarding the special circumstances in which you and your Covered Dependents may elect to continue coverage.~~

1. ~~**Termination of This Certificate:** We provide coverage under this Certificate pursuant to the terms of the Group Master Contract between the Employer Group and us. The Employer Group contract is effective for a fixed term. The Employer Group and we may renew such contract. Upon termination of the Employer Group contract, we will no longer provide any Benefits, except as described in Section 8.~~

~~2.~~1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Certificate. Failure ~~of the Employer Group~~ to remit premium payments to us in accordance with these terms may result in the suspension of Benefits for ~~all Certificate Holders~~you and ~~their covered~~your Covered Dependents. In the event ~~the Employer Group does~~you do not respond timely to written and verbal demands for payment by us, coverage under this Certificate will be terminated retroactive to the last day of the month for which premium payment was received. ~~Enrollees terminated due to non-payment of premiums are not eligible for conversion to an individual policy as described in Section 8.~~

3. **If You Are No Longer A Member Of The Employer Group:** If your employment or membership in the Employer Group terminates or you no longer meet the eligibility requirements as set forth in Section 2.8, your coverage under this Plan will automatically terminate on the date through which the Employer Group premium has been paid on your behalf. You may have the right to continue coverage. See Section 8 for a description of how you, your covered spouse, and your dependents may elect to continue coverage under certain circumstances.

4.2. **Certificate Holder's Death:** Coverage for Covered Dependents under this PlanCertificate will automatically terminate on the date of the Certificate Holder's death. For a description of how Covered Dependents can elect to continue coverage following the death of the Certificate Holder, please refer to Section 8.

3. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.

5.4. **Termination of Your Marriage:** If you divorce, legally separate, or annul your marriage, the coverage of the Certificate Holder's spouse will automatically **terminate on the date of the** divorce, legal separation, or annulment. A court order requiring the Certificate Holder to provide coverage for the former spouse does not change the termination of coverage. However, see Section 8 for information about how a Certificate Holder's spouse can elect to continue coverage.

6.5. **Termination of Coverage of A Dependent Child:** The coverage of a Child under this Certificate will terminate automatically on the earliest of the following dates on which the Child:

A. No longer meets the limiting age eligibility requirements;
B. For a Child incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support; termination of coverage based upon age limitation(s) does not apply to a Child who qualifies as an incapacitated Child.

See Section 8 for a description of how your Child can elect to continue coverage.

75. **Our Option to Terminate This Certificate:** We may terminate this Certificate for any of the following reasons:

A. An Enrollee's intentional misrepresentation of material fact or fraud committed by the Enrollee in connection with any Claim for Benefits filed under this Certificate;
B. Upon 30 days advance written notice to an Enrollee if he or she persistently fails to cooperate in good faith with the administration of coverage under this Certificate or persistently refuses to comply with treatment plans prescribed by a physician and approved by us;
C. An Enrollee's coverage for failure to pay any applicable Cost Sharing Amount required under this Certificate upon 30 days advance written notice to such Enrollee unless default in payment is cured within such 30-day period;
D. Upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's QualChoice identification card or if the Enrollee otherwise cooperates in the unauthorized use of the Enrollee's identification card or Benefits;
E. Each Enrollee represents all statements made in his or her application for membership, and any applications for membership of dependents, are true to the best of his or her knowledge and belief. If an Enrollee performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, we may void his or her enrollment under this PlanCertificate and the enrollment of his or her covered spouse and dependents or we may terminate the Plan Sponsor. No statement made, for obtaining coverage, will void coverage unless the statement is written in the application and you, the Certificate Holder, signsigns it;
F. Failure of an Enrollee to provide information necessary for QualChoice to comply with applicable law, including, but not limited to, the Enrollee's social security number or other government issued identification number; or
G. An Enrollee becomes eligible to enroll in a group health plan or government run health plan and all pre-existing conditions are covered under such group health plan or government run health plan; or

~~G.~~H. Failure to respond to a request for Recovery of Overpayment in accordance with the provisions of Section ~~12~~10.8.

QualChoice will notify the affected Enrollee of a decision to terminate the Enrollee's coverage pursuant to the requirements of applicable law. If QualChoice terminates the coverage of an Enrollee, ~~premium payments received by QualChoice on account of the terminated Enrollee applicable to periods after the effective date of termination shall be refunded to the Employer Group, less any un-recovered Benefits paid by us, within 30 days or in the next scheduled billing cycle, and~~ QualChoice shall have no further liability under this Certificate.

~~8. **Employees**~~6. **Enrollees on Military Leave:** ~~Employees~~Enrollees (or an ~~Employee's~~Enrollee's Covered Dependent) called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights apply to covered ~~Employees~~Enrollees and their Covered Dependents immediately before leaving for military service. The following applies to this election:

A. The maximum period of coverage of a person under such an election shall be the lesser of:
   1. The 24 month period beginning on the date on which the person's absence begins; or
   2. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

B. A person who elects to continue health plan coverage must pay up to 102% of the full ~~Employee~~ contribution, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

C. ~~An exclusion or Waiting Period may not be imposed in connection with reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period~~An exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed services.

~~9. **Employer Termination of Enrollee:** If the Employer Group terminates coverage of an Enrollee, the Employer Group must request QualChoice to refund premiums paid for such Enrollee's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer Group to make a refund request within 60 days of the effective date of termination of the Enrollee's coverage shall result in the Employer Group waiving refund of any premiums paid for such coverage. If Benefits have been paid past the termination date, QualChoice, in its sole discretion, may deduct the payments made for Benefits from premium refunds. If the amount paid by QualChoice for Benefits after the date of termination is greater than the premium refund amount, the Enrollee will be liable for any excess payments made for Benefits. QualChoice has the right, in its sole discretion, to pursue all legal remedies to recover funds due.~~

~~10~~7. **Hospital Confinement at Time of Termination**: If an Enrollee is facility confined on the date coverage under this Certificate terminates, coverage for such hospitalization will be determined according to the following criteria:

A. If the ~~Employer Group~~ Enrollee replaces this ~~Plan~~Certificate with other ~~group~~ coverage, coverage for the Enrollee will continue until facility discharge or Benefits under this ~~Plan~~Certificate are exhausted, whichever occurs first;

B. If the ~~Employer Group~~Enrollee **does not** replace this ~~Plan~~Certificate with other ~~group~~ coverage, coverage for the Enrollee will cease on the effective date of termination; or

C. If termination is a result of rescission of coverage by QualChoice, coverage ends on the effective date of such rescission~~; or~~ .

~~D. If the Enrollee terminates coverage independent of the Employer Group, coverage ends on the effective date of termination.~~

If the hospitalized Enrollee is the Certificate Holder, coverage for any Covered Dependents of this Enrollee ends on the effective date of termination.

6. COORDINATION OF BENEFITS

You and your family members may have coverage under more than one health plan. This ~~Plan~~Certificate contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. ~~There is no COB for prescription drugs supplied at the retail pharmacy.~~ COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1 How COB Works

The order of benefit determination rules govern the order in which each health plan will pay a claim for benefits. The health plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another health plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all health plans do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2 Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary plan coverage:

1. If a health plan does not have a COB provision, that plan is primary.
2. The health plan covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health plan that covers the person as a dependent is secondary.
3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health plan the order of benefits is determined as follows:

A. For a child whose parents are married or are living together, whether or not they have ever been married:

(1) The health plan of the parent whose birthday falls earlier in the calendar year is primary; or

(2) If both parents have the same birthday, the health plan that has covered the parent the longest is primary.

B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);

(2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) Plan of the custodial parent;

(b) Plan of the custodial parent's new spouse (if remarried);

(c) Plan of the non-custodial parent; and then

(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health plan of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The health plan covering that same person as a retired or laid-off employee is secondary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health plan, the health plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health plan does not have this rule, and as a result, the health plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

~~6~~7. The health plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health plan that covered the person the shorter period of time is secondary.

~~7~~8. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health plans. In addition, this ~~Plan~~Certificate will not pay more than it would have paid had it been primary.

~~6.3 Rules to Determine Primary and Secondary Plans for Medicare Recipients~~

~~Notwithstanding any of the rules described in Section 6.2 above, if your Employer Group has less than 20 employees, Medicare is primary for Enrollees eligible for Medicare due to age or disability.~~

~~If your Employer Group has between 20 and 100 employees:~~

~~1. Medicare is secondary for active employees and their Covered Dependents eligible for Medicare due to age;~~
~~2. Medicare is primary for active employees and their Covered Dependents eligible for Medicare due to disability;~~
~~3. Medicare is primary for non-working members and their Covered Dependents eligible for Medicare due to age or disability.~~

~~If your Employer Group has more than 100 employees,~~

~~1. Medicare is secondary for active employees and their Covered Dependents eligible for Medicare due to age or disability;~~
~~2. Medicare is primary for non-working members and their Covered Dependents eligible for Medicare due to age or disability;~~
~~3. A Member eligible for Medicare based solely on end stage renal disease is entitled to receive the Benefits of this Plan as primary for 30 months only beginning with the month of Medicare entitlement.~~

~~Medicare will be primary for members who are not subject to the above guidelines of this provision and are Medicare eligible due to age or disability.~~

~~6.4~~6.3 Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan covering the Enrollee. This means an expense or service not covered by any plan covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans cover you and compute their benefit payments based on that plan's maximum allowable payment, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans and the Allowable Expense is determined by more than one method, the primary plan's payment arrangement shall be the Allowable Expense for all plans.

6.~~5~~4 Reduction of Benefits

When this ~~Plan~~Certificate is secondary, we will reduce our benefits so that the total benefits paid or provided by all plans are not more than one hundred percent (100%) of the total Allowable Expense of the primary plan.

A. In determining the amount to be paid for any claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary plan. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total Benefits paid or provided by all health plans for the claim do not exceed the total Allowable Expense of the primary plan for that claim.
B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.
C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.~~6~~5 Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the ~~Plan~~Certificate and other health plans. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the ~~Plan~~Certificate and other health plans covering the person claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.~~7~~6 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under this ~~Plan~~Certificate. If it does, QualChoice may pay that amount to the other plan that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.~~8~~7 Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.~~9~~8 Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by ~~anothera~~ group health plan that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary plan for those services and expenses associated with that hospital admission. As the primary plan, that group health plan will be responsible for those services and expenses until the end of that hospital admission or until

the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

7. MEDICARE PRIMARY PAYER

Provision of Benefits for Medicare recipients will be determined based on the Guidelines to Determine Primary and Secondary Plans for Medicare Recipients found in Section 6.3.

When Medicare pays as the primary coverage, Medicare must approve and allow all services. We will consider the services covered by Medicare for reimbursement under this Plan as follows:

1. We pay Benefits as if you have both Parts A and B of Medicare.
   A. Part A is the coverage for in-patient care. The Medicare per confinement deductible will be covered under this Plan and reimbursement made directly to the facility.
   B. Part B is for all other care and has both deductible and coinsurance. If you do not take Medicare Part B, we will reimburse only 20% of the eligible charge. You will be responsible for the deductible and 80% of the eligible charge.
2. Medicare does not cover some services eligible under this Plan. For the services Medicare does not cover, we will consider reimbursement of the services based on the terms and conditions of this Certificate.
3. All of the other terms, conditions and limits applying to this Certificate, apply to this Benefit.

You must first file all charges with Medicare. You will receive the Explanation of Medicare Benefits (EOMB) giving payment or denial information. Send a copy of the EOMB to us with our Claim for Benefits form. You can obtain claim forms from your Employer Group or us.

8. CONTINUATION OF COVERAGE

Certain state and federal laws and regulations are applicable to your coverage under this Certificate. Certain provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the Arkansas Insurance Code, and related regulations, as amended, affect the extent of your rights to elect to continue coverage under this Plan when coverage would otherwise end. If COBRA applies to the Plan, the Employer must provide its employees and their dependents notice of COBRA rights at the time their coverage commences under this Plan and must notify the employee or dependent of their right to elect continuation of coverage under COBRA within forty-four (44) days of the happening of a "qualifying event" under COBRA. QualChoice does not assume and has no responsibility for the Employer's obligation to provide benefits under COBRA if the Employer fails to provide these notices as described here, nor shall we be responsible for providing any COBRA notices to employees or dependents. If any provision set forth in this Section 8 describing your rights to elect continuation of coverage in certain circumstances conflicts with or contravenes any provision of any applicable law or regulation which would provide for rights which are more protective to you, such conflict shall be resolved in favor of such law or regulation.

8.1 General Rules for Continuation of Coverage

As described below, coverage under this Plan may continue for a Certificate Holder and his/her Covered Dependents in certain instances when coverage would otherwise end.

1. If you are the Certificate Holder, you may choose to continue coverage, which would otherwise end under this Plan because of (1) a reduction in your hours of employment, or (2) the termination of your employment for reasons other than gross misconduct on your part.
2. If you are the covered spouse of the Certificate Holder, you may choose to continue coverage under this Plan if you lose group health coverage for any of the following reasons:
   A. The death of the Certificate Holder;
   B. Termination of the Certificate Holder's employment (for reason other than gross misconduct) or reduction in the Certificate Holder's hours of employment;
   C. Divorce or legal separation from the Certificate Holder; or
   D. The Certificate Holder becomes entitled to benefits under Medicare.
3. If you are the divorced spouse of a Certificate Holder covered under this Certificate, you have the right, after the effective date of the divorce, to continue Benefits under this Plan for 36

months. A number of events will terminate a divorced spouse's continuation coverage rights including:

A. The divorced spouse becoming eligible for facility, medical or surgical benefits under another group plan;
B. The divorced spouse becoming entitled to benefits under Title XVIII of the Social Security Act;
C. The divorced spouse's election not to be covered under this Plan;
D. The divorced spouse's acceptance of facility, medical, or surgical coverage under a qualifying non-group contract or policy; or
E. The divorced spouse's remarriage.

Note: The Certificate Holder is required to continue to pay the Employer Group the applicable premium for continuation of coverage. This premium payment obligation may be allocated between the Certificate Holder and the divorced spouse according to their agreement or as ordered by an appropriate court.

4. A Child of a Certificate Holder has the right to continue coverage under this Plan for 36 months if coverage is lost under this Plan for any of the following reasons:
   A. The death of the Certificate Holder;
   B. The termination of the Certificate Holder's employment (for reasons other than gross misconduct) or reduction in the Certificate Holder's hours of employment;
   C. Parent's divorce or legal separation;
   D. The Certificate Holder becomes entitled to benefits under Medicare; or
   E. The dependent ceases to be a "Child" as defined under this Plan.
5. Special Coverage Extension Rules For Disabled Persons: If an individual covered under COBRA whose maximum period of coverage would otherwise be limited to 18 months is found to be totally disabled within 60 days of a qualifying event as defined by COBRA, such individual (and dependents covered under this provision) shall be permitted to extend the maximum period of continuation of Benefits to a maximum of 29 months under the following conditions:
   A. The individual must notify the Employer Group in writing within 60 days of Medicare approval but no later than the end of the initial 18 months;
   B. Should an individual on extension of continuation of Benefits recover from his or her disability to the extent such individual is no longer totally disabled, as defined below, continuation of Benefits shall be terminated as of the first day of the month following a period of not less than 30 days from the date the individual is no longer totally disabled; and
   C. The term “totally disabled” with respect to this section shall mean the individual is actually receiving, or is entitled to receive, Social Security Disability Benefits. When a person has a claim for Social Security Benefits for a disability occurring on or prior to the date of the qualifying event, and Social Security is disputing the disability claim but has not denied it, and the person has paid for continuation coverage for the maximum period otherwise allowable, the Plan will continue to accept premium payments for the extension period until a final decision is reached by Social Security. However, we will pay no Claim for Benefits until Social Security has awarded disability benefits. Should Social Security deny the claim or establish a date of disability after the date of the qualifying event, we will refund all payments made for extended coverage to the affected person.
6. The Certificate Holder or eligible Dependent has the responsibility to inform the Employer Group within 60 days of a divorce, legal separation, or loss of Child status. When the Employer Group is so notified or when one of the other qualifying events has occurred, the Employer Group will notify the Certificate Holder and/or eligible dependents (as appropriate) of the right to choose continuation of coverage. The Certificate Holder and/or eligible dependents will have 60 days to elect continuation of coverage from the later of: (1) the date coverage would be lost because of one of the events described above or (2) the date of notice of the right to elect continuation of coverage. If continuation coverage is not elected, the coverage will end.

7. The continuation coverage under this Plan will be identical to the coverage provided to similarly situated Certificate Holders or eligible dependents. Continuation coverage under this Plan for the Certificate Holder and/or eligible dependents will end if:
    A. The Group no longer provides our coverage to any of its employees;
    B. The premium for continuation coverage is not paid;
    C. Coverage is provided under another group health plan; or
    D. The Enrollee becomes entitled to benefits under Medicare (coverage under this Plan terminates only for the Enrollee who becomes eligible for Medicare).
8. There is no need to show insurability to choose continuation coverage. However, as permitted under the law, we may charge up to 102% of the normal premium for continuation coverage. At any time, an Enrollee is entitled to continuation of coverage, or at the time of termination of coverage, an option to enroll in an individual conversion health plan (commencing upon termination of coverage) will be available.
9. If coverage under this Plan terminates because of the Employer Group's bankruptcy petition under Chapter 11 of Federal bankruptcy law, or if coverage is substantially eliminated during the period beginning one year before and ending one year after the commencement of such a bankruptcy proceeding, continuation coverage may continue (if provided by the Employer Group) for the life of a retired Certificate Holder or for 36 months after the death of a retired Certificate Holder for a covered spouse or a Child. However, continuation coverage under this Plan may be terminated for the retired Certificate Holder and/or Covered Dependents for any of the following reasons:
    A. The Employer Group no longer provides our coverage to any of its employees;
    B. The premium for continuation coverage is not paid; or
    C. Another group health plan provides the coverage.

8.2 Transfer of Continuation of Coverage

In addition to Enrollees who are eligible for either federally or state mandated continuation of coverage under the terms of this section, the following individuals are also eligible to receive continuation coverage:

1. Those individuals who were covered under a continuation provision of an employer's prior health care benefit plan, when the employer changes coverage of its active employees from the prior coverage to coverage under this Plan. We will cover such individuals without the imposition of any Waiting Period, although they will be subject to the same applicable Cost Sharing Amounts and other coverage conditions, limitations and exclusions as are other active employees who join this Plan.
2. Those individual dependents were covered under a continuation of coverage provision of an employee's prior coverage will be covered, if the employee changes from such prior coverage to coverage with us. These individuals with continuation of coverage will be subject to the same applicable Cost Sharing Amounts and other coverage conditions, limitations and exclusions as the transferring employee.

8.3 Conversion to Non-Group Enrollment

When coverage terminates, Enrollees may convert hospitalization and certain medical Benefits to a non-group policy without taking a medical examination as long as they meet the requirements listed below. The cost for non-group coverage will be the non-group rates for the health care benefit plan available. (These Benefits will not be the same as those under this Plan.) You may choose to utilize the conversion privilege under this Certificate and thereby waive your right to continuation of coverage. You may obtain an application for conversion by calling our Customer Service Department. You may convert to non-group enrollment if you meet the following requirements:

1. You cease to be eligible as an Enrollee for any reason other than those outlined in Section 5.4(7), ("Our Option to Terminate This Certificate"); and
2. You submit the required application and pay the initial premium within the later of 30 days from the date the member's coverage terminates or the date the plan notifies the member of the member's right to convert.

We will make coverage under the non-group policy effective as of the date of termination of your coverage under this Plan.

~~8.4 State Continuation of Coverage~~

~~If COBRA does not apply to the Plan, the Certificate Holder or an Enrollee may be eligible for Benefits beyond the date of termination of employment or change in eligibility under this Certificate through state continuation coverage. In order to qualify for continuation of coverage, the Certificate must cover the individual continuously under this Certificate for the three (3) month period prior to the termination of employment or change in marital status.~~

1. ~~The continuation of coverage is for medical services only. If this Certificate contains riders for dental services, vision services, or prescription drug expenses, these services are not included in this continuation of coverage. Continuation of coverage shall not be available to an individual who is eligible for:~~
   - ~~A. Federal Medicare coverage; or~~
   - ~~B. Full coverage under any other group health policy or contract.~~
2. ~~Any individual who wishes to obtain continuation of coverage must request continuation of coverage within ten (10) days after the termination of employment or membership or change in marital status. You must pay premiums to the Group on a monthly basis and in advance. You must make payments for the appropriate coverage level for the individual and any dependents electing continuation of coverage.~~
3. ~~Continuation of coverage shall end upon the earliest of the following dates:~~
   - ~~A. One hundred twenty (120) days after continuation of coverage begins;~~
   - ~~B. The end of the period for which the individual made a timely contribution;~~
   - ~~C. The contribution due date following the date the individual becomes eligible for Medicare;~~
   - ~~D. The date on which the individual is covered for similar benefits under another group or individual policy;~~
   - ~~E. The date on which the individual becomes eligible for similar benefits under another group or individual policy; or~~
   - ~~F. The date on which the Group terminates the Group Contract or withdraws from us.~~

~~9~~7. Complaints and Appeals

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of ~~Plan~~Certificate language, and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and binding on the Enrollee and this ~~Plan~~Certificate. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

~~9~~7.1 Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Certificate. Our Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request a Level I Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 9.3 below. An "appeal" must be initiated and conducted as described in Section 9.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Department at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator

P. O. Box 25610
Little Rock, Arkansas 72221-5610

4. **Complaint Resolution:** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

~~9~~7.2 Types of Requests and Claims

1. **Pre-Service Claim:** A Pre-Service Claim is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Certificate.
2. **Post-Service Claims:** Post-Service Claims are those claims for services that have already been received by the Enrollee.
3. **Urgent Care Claim:** An Urgent Care Claim is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:
   A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or
   B. Life, health or ability to regain maximum function could be seriously jeopardized.
4. **Concurrent Care Claim**: A Concurrent Care Claim is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.
6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

~~9~~7.3 Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Level I Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Claim, Concurrent Care Claim or Urgent Care Claim) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 9. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator
   P.O. Box 25610
   Little Rock, AR 72221-5610

2. **Appeal of Pre-Service Claim and Concurrent Care Claim**
   A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee, and respond as soon as possible, but not later than fifteen (15) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
   B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will

assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **Initiating a Pre-Service or Concurrent Care Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing ~~or facsimile~~ to our Complaint and Appeals Coordinator at the address listed in Subparagraph 1 above.

D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider have the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within fifteen (15) calendar days of the Committee's hearing.

E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within fifteen (15) calendar days from the receipt of the appeal.

F. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Claim or Concurrent Care Claim will be treated as an appeal of an Urgent Care Claim as described in Section 9.3 below subject to the request meeting the criteria for an Urgent Care Claim.

3. **Appeal of Post-Service Claims**

A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer, will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee and respond with a decision as soon as possible, but not later than thirty (30) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **Initiating a Post Service Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing or facsimile to our Complaint and Appeals Coordinator at the address or fax number listed in Subparagraph 1 above.

D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within thirty (30) calendar days of the Committee's hearing.

E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and

any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within thirty (30) calendar days from the receipt of the appeal.

F. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Claim**

A. **Initiating a Level I Appeal and Level II Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413. An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

B. **Level I Appeal and Level II Appeal.** An appeal of an Urgent Care Claim will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review. A medical director different than the one that made the Level I Appeal decision will make the Level II Appeal decision.

~~9~~7.4 Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Claim as defined in Section 9.2 above can initially be submitted orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Claim appeal even though investigation will have begun.
2. **Right to Information of Enrollee:** We shall provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:
   A. Were relied upon in making the benefit determination;
   B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
   C. Demonstrate compliance with the terms of the ~~Plan~~Certificate; and
   D. Constitute a statement of policy or guidance with respect to the ~~Plan~~Certificate concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Claim or Concurrent Care Claim, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the

appeal do not accompany the appeal of a Medical Issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

~~9~~7.5 Conduct of Appeals

An appeal is conducted following the procedures below:

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.
2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by QualChoice with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

~~9~~7.6 Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

~~9~~7.7 Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.
2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.
3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:
    A. An individual designated by the Enrollee in writing in a form approved by us;
    B. The treating provider, if it is a Pre-Service Claim, a Concurrent Care Claim, or an Urgent Care Claim, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
    C. A person holding the Enrollee's durable power of attorney;
    D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
    E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.

4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.
5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

   If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Claim or Concurrent Care Claim, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

~~9~~7.8 External Medical Review

After you have exhausted your Level I and Level II appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Claim, please contact QualChoice's Appeal Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in the ~~Plan~~Certificate, an express limitation in the ~~Plan~~Certificate, dollar limits under the ~~Plan~~Certificate, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on both you and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

~~10~~8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this section. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 10 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if you have an injury or illness caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for your Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If you receive payment from a third party or any other insurer for the cost of Covered Services, you are obligated to reimburse us. You may reduce such reimbursement by our pro rata share of reasonable attorney's fees and costs you incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 10. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance as we may reasonably require to fully enforcing the terms of this Section 10. You agree to take no action prejudicing our rights and interests under this Section 10.

~~11~~9. PRE-EXISTING CONDITIONS

No Benefits for services of any kind are provided under this Certificate for treatment of a Pre-existing Condition (as defined in the Section ~~13~~11) for a period of 12 months ~~for Enrollees (18 months for a Late Enrollee) making application for coverage after the~~ from an Enrollee's effective date of ~~the Group Master Contract.~~coverage under the prior employer group policy. This 12-month ~~(18-month for a Late Enrollee) period may also be applied for Enrollees enrolling during the Open Enrollment period. This 12-month (18-month for a Late Enrollee)~~ period is referred to as the "pre-existing period". If the Enrollee ~~submits~~submitted an application for coverage during ~~the~~their initial Waiting Period under the prior employer group policy, the pre-existing period begins on the first day of the Waiting Period. If the ~~Member does~~Enrollee did not apply for coverage within the Waiting Period, the pre-existing period begins on the ~~Member's~~Enrollee's original effective date under the prior employer group policy.

~~11~~9.1 Periods of Creditable Coverage

Periods of Creditable Coverage (as defined in applicable law and regulations) will reduce the Pre-existing Condition exclusion period. For purposes of this Certificate, Creditable Coverage includes the coverage an Enrollee had under the prior employer group policy. The notification an Enrollee receives from us sets out the Enrollee's Pre-existing Condition period as calculated by us. In reaching this determination, we consider Certificates of Creditable Coverage provided by the Enrollee's prior health plans and health insurers as well as information otherwise available to us.

Failure to cooperate fully shall constitute grounds for affirming any original Pre-existing Condition exclusion period determination, and denying Claims on that basis.

~~11~~9.2 Applicability of Pre-existing Exclusion

This Pre-existing Condition exclusion is not applicable to:

~~1. Pregnancy; or~~

1. Pregnancy if you or your enrolled spouse is pregnant as of the effective date of this Certificate; or

2.– An Enrollee under the age of 19.

~~11~~9.3 Request for Reconsideration of Pre-existing Condition Limitation Period Determination

How to request a reconsideration of a Pre-existing Condition Limitation Period Determination:

1. ~~1.~~ If an Enrollee disagrees with the Pre-existing Condition limitation period calculated by us, the Enrollee can ask for a reconsideration of this determination by sending a written request to:

   Enrollment Department
   QualChoice
   P.O. Box 25610,
   Little Rock, AR 72221-5610

2. ~~2.~~ An Enrollee's request for reconsideration must include a written statement of the correct period of time the Enrollee had Creditable Coverage and relevant evidence to corroborate the Enrollee's statement. Relevant evidence can include Certificate(s) of Creditable Coverage issued by prior health plans, explanation of benefits, claims or other correspondence from a health plan indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a benefit certificate, or the telephone number of the Member's prior heath plan.
3. ~~3.~~ By requesting reconsideration of the determination of a Pre-existing Condition limitation period, the Enrollee agrees to cooperate with efforts to verify prior coverage. Cooperation includes, but is not limited to, providing written authorization to request a certificate on the Enrollee's behalf from prior health plan(s) and insurer(s), providing information about the Enrollee's prior health plan(s) and insurer(s), such as telephone numbers and addresses, and assisting the efforts to determine the validity of the corroborating relevant evidence.
4. ~~4.~~ We will make our final determination of an Enrollee's Pre-existing Condition limitation period within a reasonable period of time after it receives the Enrollee's written request for reconsideration.
5. ~~5.~~ Appeals from a denial of a Claim based on the Pre-existing Condition exclusion (as distinguished from appeals concerning the calculation of the Pre-existing Condition limitation period) should follow the general appeal procedures outlined in Section 9.

~~12~~10. GENERAL PROVISIONS

~~12~~10.1 Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under ~~the Group Policy or Group Master Contract, including the terms of~~ this Certificate. If we do so, we will give thirty (30) days written notice to ~~your Employer or its agent~~you and the change will go into effect on the date fixed in the notice.

~~12~~

10.2 Assignment

You cannot assign any Benefits or monies due under this Certificate to any person, corporation, organization or other entity. Any assignment by you will be void and have no effect. Assignment means the transfer of your right to the Benefits provided under this Certificate.

~~12~~10.3 Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. ~~If permitted by applicable law, it can be mailed in care of your Employer Group.~~ Notice to us must be in writing and mailed to our offices at:

QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

~~12~~

10.4 Your Medical Records

We may need to obtain copies of your medical records from any of your treating providers. This may be necessary to properly administer your Benefits. You, or your legal representative, agree to sign an appropriate authorization for release of medical records upon our request. If you elect not to consent to the release of medical records, we may be unable to properly administer your coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

~~12~~10.5 Request for Certificate of Creditable Coverage

You may request from us at any time a Certificate of Creditable Coverage by contacting our Customer Service Department.

~~12~~10.6 Notice of Claim

We must receive your Claim for Benefits within no more than 12 months from the date you receive the service. Failure to meet this requirement will result in payment denial.

~~12~~10.7 Who Receives Payment Under This Certificate

We will make payments under this Certificate directly to the Network Providers providing care. ~~If you receive Covered Services from any Out-of-Network Provider, we reserve the right to pay either you or the provider.~~

~~12~~10.8 Recovery of Overpayments

On occasion, an incorrect payment may be made to you. Reasons for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem to you in writing. You must return to us within 60 days the amount of the mistaken payment. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

~~12~~10.9 Confidentiality

Medical records and other information concerning your care we receive from providers are confidential. We will use such information only to administer your coverage. We will only disclose such information as required to coordinate Benefits or assure continuity of care. Other disclosures require your written consent. See your Notice of Privacy Practices for a more detailed description of your privacy rights and duties. ~~However, notwithstanding the limitations described in this Section 12.9, by your acceptance of benefits pursuant to this Certificate, you authorize QualChoice to~~

~~disclose to your Employer Group sponsoring the Plan information concerning your care to the extent necessary for QualChoice to comply with the requirements of Arkansas Code Annotated § 23-86-119. Arkansas Code Annotated § 23-86-119 requires health companies like QualChoice to release to employer groups with more than twenty-five (25) insured employees upon the employer's request the following information for the most recent twelve-month period or for the entire period of coverage, whichever is shorter: (a) Claims incurred by month; (b) Premiums paid by month; (c) Number of insureds, including dependents, by month; and (d) Claims exceeding ten thousand dollars ($10,000) on any individual with diagnosis during the same period.~~

~~12~~10.10 Complaint and Appeals

You are entitled to have any complaints heard by us. We are obligated to hear and resolve such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures for complaints and appeals set forth in Section 9 will be followed.

~~12~~

10.11 Right to Develop Policies and Guidelines

We reserve the right to develop or adopt policies and guidelines for the administration of Benefits under this Certificate. These policies and guidelines will be interpretive only and will not be contrary to any terms of this Certificate. If you have a question about the policies or guidelines used to apply to a particular Benefit, you may contact us or visit our website at ~~www.qualchoicequalchoice.com~~www.qualchoice.com for further information.

~~12~~10.12 Limitation on Benefit of This Certificate

No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Certificate. The covenants, undertakings, and agreements set forth in this Certificate shall be solely for the benefit of our Enrollees and us.

~~12~~10.13 Applicable Law

This Certificate, the rights and obligations of our employees and us under this Certificate, and any claims or disputes relating thereto, shall be governed by and construed in accordance with Federal and Arkansas law.

~~12~~10.14 Headings

Section and subsection headings contained in this Certificate are inserted for convenience of reference only. They shall not be deemed to be part of this Certificate for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

~~12~~10.15 Pronouns

All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

~~12~~10.16 Severability

If any part of any provision of this Certificate or any document or writing given pursuant to or in connection with this Certificate shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Certificate.

~~12~~10.17 Waiver

The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Certificate shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Certificate or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

~~13~~11. DEFINITIONS

There are other definitions, usually capitalized, contained in various sections throughout this Certificate. The capitalized words or terms used in this Certificate and are not otherwise defined have the meanings set forth below:

~~13~~11.1 "Accidental Injury" means a bodily injury (other than intentionally self-inflicted injury) happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent of disease or bodily infirmity. Accidental Injury to teeth does not include any damage caused by chewing or biting any object.

~~13~~11.2 "Benefits" means reimbursement or payments for health care available to Enrollees covered under this ~~Plan~~Certificate.

~~13~~11.3 **"Benefits Summary"** ~~(which may be referred to in some QualChoice documents as the "Cost Sharing Table")~~ means a document containing specific information relating to your coverage and Cost Sharing Amounts under this ~~Plan~~Certificate. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum benefits as well as visit and day maximums for limited services.

~~13~~11.4 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

~~13.5~~11.5 **"Certificate"** means this conversion medical benefits policy through which Benefits are provided, in whole or in part, as reflected in this Certificate.

11.6. **"Certificate Holder"** means you, the ~~individual Employer Group member,~~person to whom this Certificate is issued.

~~13.6~~11.7 **"Child"** means the Certificate Holder's natural child, legally adopted child, child for whom the Certificate Holder is the legal guardian, or stepchild. "Child" also includes a child for whom the Certificate Holder is the adoptive parent during the Waiting Period prior to completing the adoption. Foster children are not included in the definition of "Child".

~~13.7~~11.8 **"Claim for Benefits" or "Claim"** means (i) a request for payment or prior approval (when required under the ~~Plan~~Certificate) for a service, supply, medication, equipment or treatment covered by the ~~Plan~~Certificate, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee's authorized representative, and (iii) is submitted consistent with QualChoice's standard claim filing policies and procedures (copies of which are available on request).

~~13.8~~11.9 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge you must pay toward the cost of certain Covered Services. Those Covered Services subject to the application of Coinsurance are identified in your Benefits Summary. Coinsurance is subject to an annual maximum limit.

~~13.9~~11.10 **"Complication of Pregnancy"** means a condition requiring facility confinement, when the pregnancy is not terminated, the diagnosis of which is unrelated to the pregnancy but causes the mother's health to be adversely affected. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity which threaten the mother's health or life.

The following will also be considered a Complication of Pregnancy:

1. A c-section occurring after failure of a trial of labor;
2. An emergency c-section required because of fetal or maternal distress during labor;
3. An ectopic pregnancy which is terminated;
4. A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and
5. A non-scheduled c-section.

~~13.10~~11.11 **"Co-payment"** means a fixed dollar amount you must pay each time you receive a particular Covered Service to which a Co-payment applies.

~~13.~~11.12 **"Cost Sharing Amount"** means an amount you are required to pay each time you receive a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in your Benefits Summary.

11.13.12 **"Covered Dependent"** means any member of the Certificate Holder's family who meets the eligibility requirements of Section 5, who is enrolled in the PlanCertificate, and for whom we have received premium.

13.1311.14 **"Covered Service(s)"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Certificate. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the definition of "Medically Necessary" in this section and the other qualifications set forth in Section 3.

13.1411.15 **"Custodial Care"** means provision of routine care that is primarily for meeting personal needs, including assistance with activities of daily living.

13.1511.16 **"Deductible"** means a certain fixed dollar amount you must incur before we begin to pay for the cost of Covered Services provided to you during each Calendar Year. Each Enrollee must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.

13.1611.17 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

13.17 **"Employer Group"** means the business or entity to which this Plan is issued.

1311.18 **"Enrollee"** means a Certificate Holder and any spouse of a Certificate Holder or dependents of the Certificate Holder or of the Certificate Holder's spouse covered under this Certificate.

1311.19 **"Enrollment Application"** means the form to be accurately completed by prospective Certificate Holders when they apply for enrollment under our Group Master Contract. An Enrollment Application is available from your Employer Group.

13.20 **"Group Master Contract"** means the contract issued to the Employer Group by us, of which this Certificate is part thereof.

13.2111.20 **"High Dose Chemotherapy"** means Chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., granulocyte, colony-stimulating factor, granulocyte-macrophage colony-stimulating factor, reinfusion of stem cells, reinfusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any Enrollee who received this High Dose Chemotherapy, to prevent life threatening complications of the chemotherapy on the Enrollee's own blood cells.

13.22
11.21 **"Injectible Prescription Medications"** means any injectible pharmaceutical that has been approved by the Food and Drug Administration and can be obtained only through a prescription. .

13.23 **"Late Enrollee"** means an individual who enrolls in this Plan other than on the earliest date on which coverage can become effective under the terms of the Plan and other than on a special enrollment date.

13.2411.22 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits under this Certificate are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much your health care provider may bill for a given service, the

Benefits under this Certificate will be limited by the Maximum Allowable Charge we establish. If you use a QualChoice Network Provider and QualChoice is the primary payor, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, **if you use an Out-of-Network Provider~~,~~ you will be responsible for all amounts billed ~~in excess of the QualChoice Maximum Allowable Charge~~**.

~~13.25~~11.23 **"Medical Advisory Committee"** means an internal committee composed of practicing physicians selected by QualChoice from the Arkansas medical community.

~~13.26~~11.24 **"Medical Policy" or "Medical Policies"** means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit certificate or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

~~13.27~~11.25 **"Medically Necessary" or "Medical Necessity"** means a Covered Service, which in the opinion of our medical personnel:

A. Provides for the diagnosis or treatment of the Enrollee's covered medical condition;
B. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's illness, injury or medical condition in relation to any overall medical/health conditions;
C. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
D. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
E. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

~~13.28~~11.26 **"Mental Health or Substance Use Disorder"** means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & Statistical Manual of Mental Diseases of the American Psychiatric Association (DSM) classification.

~~13.29~~11.27 **"Network Facility"** means a hospital facility or other facility (e.g., hospice, ambulatory surgery center, etc.) that has entered into an agreement with us to make Covered Services available to Enrollees.

~~13.30~~11.28 **"Network Primary Care Physician"** means a physician who has entered into an agreement with us regarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilized by an Enrollee as his or her primary care physician. The following will be considered to be a primary care physician: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

~~13.31~~11.29 **"Network Provider"** means a Network Primary Care Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

~~13.32~~11.30 **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with us regarding, among other things, willingness to provide specialty Covered Services to Enrollees and who may be utilized by an Enrollee as his or her specialty physician. The following will not be considered to be a specialist: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

~~13.33 **"Open Enrollment"** means a period during which eligible employees and their eligible dependents may join or transfer from one health plan to another. Enrollees who have previously been declined coverage or whose coverage has been terminated for any reasons set forth in Section 5 will not be eligible to join this Plan during Open Enrollment.~~

~~13.34~~11.31 **"Out-of-Network Provider"** means a physician, facility or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees. Regardless of any other provision in this Certificate, the extent of QualChoice's coverage for services provided by an Out-of-Network Provider is as set forth in your Benefits Summary.

~~13.35~~11.32 **"Out-of-Pocket Limit"** means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

~~13.36 **"Plan"** means this group medical benefits plan which has been established by the Employer Group and through which Benefits are provided, in whole or in part, under the Group Master Contract as reflected in this Certificate.~~

~~13.37~~11.33 **"Pre-existing Condition"** means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on (1) the Member's effective date with the ~~Plan~~Certificate or (2) the first day of their Waiting Period, as applicable. The period is calculated by counting back from the first day of the Waiting Period, rather than from the Member's actual effective date. If the Member does not apply within the Waiting Period, the 6-month period is calculated by counting back from the Member's effective date of coverage.

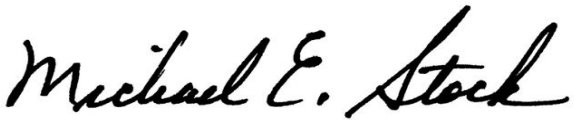
Notwithstanding the definition above, with respect ONLY to an Enrollee who is under nineteen (19) years of age, "Pre-existing Condition" means a condition that was present before the effective date of coverage, or if coverage is denied, the date of the denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition can be identified through information relating to health status before the Enrollee's effective date of coverage or if coverage is denied, the date of the denial, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the Enrollee, or review of medical records relating to the pre-enrollment period.

~~13.38~~11.34 **"Referral"** means a specific written approval from us that an Enrollee seeks for additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Certificate. We issue Referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you are completed during the appropriate period. ~~If~~There will be no coverage for services ~~are~~ rendered outside the approved period~~, Benefits will be allowed at Out-of-Network reimbursement levels~~.

~~13.39~~11.35 **"Service Area"** means the geographical area in which we are licensed by the State of Arkansas to conduct business.

~~13.40~~

11.36 **"Waiting Period"** means the period from your date of hire until the date you ~~are~~were first eligible for coverage under ~~this Plan. In the event you are being re-hired by the Employer Group and the Employer Group has a written~~your employer group policy ~~that reduces or eliminates the Waiting Period for former employees who were participants in the Plan as long as that former employee is re-hired within a specified timeframe, QualChoice will honor that Employer Group's policy as long as the specified timeframe for re-hire does not exceed six (6) months. If the Employer Group's re-hire policy exceeds six (6) months, then any person re-hired after six (6) months will be treated by QualChoice as a new hire.~~.



Michael E. Stock, President & CEO
QCA Health Plan, Inc.
The QualChoice Building
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Withdrawn 07/28/2011	QCA Conversion (8-11)	Policy/Contract/Fraternal Certificate	Conversion Evidence of Coverage Certificate	Initial			
Approved-Closed 07/28/2011	QCA HMO (01-01-05) Amended Conversion	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Amendment to Conversion Evidence of Coverage	Initial			QCA Conversion Amendment Aug 2011 Revised Final.pdf

Amendment to Conversion Evidence of Coverage (Form # QCA HMO (01-01-05))

Attached is the Benefits Summary indicating name, benefits, Out-of-Pocket Limit amount, type of coverage, Preexisting Condition exclusion period, and effective date.

IMPORTANT NOTICE

COVERED SERVICES RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN VERY LIMITED CIRCUMSTANCES AS SET FORTH IN YOUR BENEFITS SUMMARY ARE NOT COVERED. REFER TO YOUR BENEFITS SUMMARY.

THIS COVERAGE CONTAINS A PREEXISTING CONDITION LIMITATION. REFER TO THE BENEFITS SUMMARY.

The benefits in this Certificate do not necessarily equal or match those benefits provided in your previous group policy.

Underwritten by:
QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
www.qualchoice.com

IMPORTANT QUALCHOICE CONTACT INFORMATION

QualChoice is committed to providing better customer support. That includes making it easy for you to contact us. You are always welcome to call us with any questions or concerns.

Website Address:

www.qualchoice.com

Our Customer Service Department can be reached:

Toll Free at (800) 235-7111

Locally at (501) 228-7111

Our QCARE Coaches can be reached:

Toll Free at (888) 795-6810

Our "Ask a Nurse" assistance line can be reached:

Toll Free at (866) 232-0447

TABLE OF CONTENTS

1. INTRODUCTION TO YOUR AMENDED CERTIFICATE

1.1. Certificate

QCA Health Plan, Inc. Inc. ("QualChoice" also referred to as "us", "we" or "our") is a licensed Health Maintenance Organization. QualChoice has a certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone number is (501) 228-7111 or toll free (800) 235-7111.

This is your Amendment to the Conversion Evidence of Coverage Certificate (Form # QCA HMO (01-01-05)) (the "EOC"). The Amendment modifies the EOC as set forth in herein. To the extent there is conflict between this Amendment and the EOC, this Amendment will control. This Amendment shall be referred to hereinafter as the "Certificate".

This Certificate is a legal document between QCA Health Plan, Inc. and you to provide Covered Services subject to the terms, conditions, exclusions and limitations included herein.

1.2. Changes to This Certificate

We may from time to time modify this Certificate through a "Rider" and/or "Amendment" that may change certain provisions of this Certificate. When this happens we will send you a new Certificate, Rider or Amendment.

1.3. Key Information

For purposes of this Certificate, "you" or "your" means the Certificate Holder.

Only we have the right to change, interpret, modify, withdraw or add Benefits, or terminate this contract, as permitted by law, without your approval.

On its effective date, this Certificate replaces and overrules any certificate that we may have previously issued to you. This Certificate will in turn be overruled by any certificate we issue to you in the future.

Your coverage under this Certificate begins at 12:01 a.m. on the effective date, which is the day following the termination of your coverage under the employer group policy. We will continue your coverage unless and until you or we terminate it for any of the reasons described in this Certificate. We determine your eligibility for Benefits under this Certificate.

This Certificate and Benefits Summary describe your Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The Benefits Summary provided to you is an integral part of this Certificate. In the event this Certificate and the Benefits Summary conflict, the Benefits Summary will control. You should locate and familiarize yourself with the Benefits Summary.

This Certificate describes some special procedures with which you must comply.

To the extent that state law applies, the laws of the State of Arkansas shall govern this Certificate.

We have capitalized certain words in this Certificate. Those words have special meanings and, unless defined otherwise elsewhere, are defined in Section 11, "Definitions".

2. HOW THIS PLAN WORKS

This Certificate provides you with a flexible choice in selecting options in obtaining health care services and how your choice may financially impact you. We encourage you to utilize a Network Primary Care Physician to assist in the coordination of your health care services under this Certificate. The utilization of a Network Primary Care Physician is a matter you control and you are not required to notify us of your Network Primary Care Physician relationship. You are always encouraged to seek care directly from a Network Primary Care Physician first. You may also seek care with any Network Physician or Provider under this Plan without a Referral. Consult your Benefits Summary to identify Covered Services and Cost Sharing amounts.

2.1 In-Network Benefits

In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider or at a Network Facility; or
2. Emergency health services meeting the QualChoice payment guidelines.

Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and meets either of these requirements will be processed as an In-Network Benefit. Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and does not meet either of these requirements will not be covered.

You should validate the status of a Network Provider by accessing the on-line directory at any time or calling Customer Service during normal business hours.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in your Benefits Summary.

You may seek Covered Services from any Network Primary Care Physician or from other Network Physicians without a Referral. Coverage for services in the office is at the primary care physician benefit level when you seek Covered Services directly from any Network Primary Care Physician. Coverage for services in the office is at the specialist benefit level when you seek Covered Services from any other Network Physician. You should validate the status of a Network Provider by calling Customer Service or accessing the on-line provider directory. Please refer to your Benefits Summary for details.

2.2 Out-of-Network Benefits

As described in your Benefits Summary, services provided by an Out-of-Network Provider are not covered unless otherwise stated in your Benefits Summary or unless prior authorization for coverage as an In-Network Benefit is received from us. Any amounts that QualChoice allows for Covered Services provided by an Out-of-Network Provider will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary for details:

1. **Certificate Provision:** The Benefits Summary or this Certificate specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Certificate, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Continuity of Care, Pregnancy, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage you were receiving obstetrical care from an Out-of-Network Provider for a pregnancy covered under the terms of this Certificate, that you were in the third trimester of your pregnancy on the effective date of your coverage, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits;
5. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If

QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;

6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Certificate, that you were in the third trimester of your pregnancy on the date that the Provider left the PPO, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing QualChoice, Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3 Network Provider Participation

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at an In-Network Benefit level. You may search the directory on our website at www.qualchoice.com or by calling our Customer Service Department at (800) 235-7111. Because contractual agreements can change, you should verify that a physician or provider is a Network Provider before you seek care.

We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if your Covered Services for that condition are approved by us prior to receiving the service.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A referral, whether written or oral, by a Network Provider to an Out-of-Network Provider; or
2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Provider to provide and coordinate all future Covered Services. If you do not make a change to a single Network Provider within 31 days of the date we notify you, we will assign a single Network Provider to you.

2.4 Cost Sharing Requirements

You must share in the cost of your Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult your Benefits Summary to determine the amounts of your payments under these Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill you for the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all charges. **These additional charges could amount to thousands of dollars in additional out-of-pocket expenses for which you are responsible.**

1. **Deductible:** The Deductible is a certain fixed dollar amount per Calendar Year, per person as set forth in your Benefits Summary.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time you receive a Covered Service to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket Limits for each Enrollee or family. Please see your Benefits Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of the Maximum Allowable Charge for the cost of Covered Services you must pay. Coinsurance payments are in addition to Deductibles or Co-payments. Your Benefits Summary contains your Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided to you.
4. **Limits on Your Out-of-Pocket Payments:** You will no longer have to pay Coinsurance for the remainder of the Calendar Year after you have met the Out-of-Pocket Limit during the Calendar Year. Your Benefits Summary lists your Out-of-Pocket Limit for Coinsurance. Coinsurance is the only amount that will apply towards your Out-of-Pocket Limit. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are your responsibility and do not count toward meeting the Out-of-Pocket Limit. Once your Out-of-Pocket Limit has been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge.

2.5 Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Certificate, and regardless of any other communications or materials you may receive in connection with your Certificate, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in . This standard applies to all sections of this Certificate.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Certificate. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.1.

2.6 Exclusion and Limitations

Some services are excluded from coverage and other services have specific coverage limitations.

This Certificate refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

Consult your Benefits Summary, Medical Policies, and Section 4.0 for information on benefit limitations and exclusions.

2.7 Enrollees Living Outside Service Area For More Than 90 Days

Enrollees that will live, work, or attend school outside the Service Area for more than 90 consecutive days should notify us. The Enrollee uses his/her QualChoice identification card to access Covered Services. Covered Services are processed at the In-Network Benefit level when provided by a QualChoice National Network (QCNN) healthcare provider. Covered Services for services not provided by a QualChoice National Network (QCNN) provider are will not be covered.

Enrollees who may use the QCNN for In-Network Benefits are:

1. Dependent students who are attending school outside the Service Area for at least 90 consecutive days, with renewal required annually; or
2. Dependent spouses and children who are living outside the Service Area for at least 90 consecutive days, with renewal required annually.

Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization for those services that we require to be pre-authorized (see Section 2.11) to receive Benefits at the In-Network Benefit level when accessing care from the QualChoice National Network (QCNN). It is the responsibility of the Enrollee to obtain the pre-authorization for Covered Services. QCNN providers are not responsible for obtaining a pre-authorization for services.

2.8 Coverage While Traveling Out of the Service Area

We cover the cost of Emergency health services an Enrollee incurs while traveling outside of the Service Area, but within the United States. An Enrollee is encouraged to seek services for Emergency health services from health care providers participating in the QualChoice National Network (QCNN) when the Enrollee is out of the Service Area. An Enrollee may limit out-of-pocket expenses for Emergency health services while outside of the Service Area to applicable Cost Sharing Amounts by accessing such care from a QCNN provider.

If care is accessed by an Enrollee from providers not participating in the QCNN, Covered Services received from such providers are not covered except in very limited circumstances as set forth in you Benefits Summary. We will deny coverage for routine and follow up care after Emergency health services unless a Network Provider in Arkansas performs the services.

The QualChoice identification card contains contact information for the QCNN. QCNN providers may be identified by calling the number on the identification card. The Enrollee must present their QualChoice identification card to the servicing provider indicating participation in the QCNN in order to receive this benefit. Submit a Claim for Benefits directly to us for processing. Provisions for Emergency health services as set forth in Section 3.10 must also be followed to receive maximum Benefits.

Dependents who have notified QualChoice that they reside outside the Service Area may access the QCNN providers and facilities for Covered Services at the In-Network benefit level upon prior approval by QualChoice.

2.9 General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of this Certificate. A final determination of eligibility is made at the time a Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a healthcare care provider, provided within the scope of that healthcare provider's license, and rendered in accordance with professionally recognized standards of care.

During the first year of this Certificate, the Benefits payable under this Certificate shall not exceed those that would have been payable had your Benefits under your former employer's group policy remained in force and effect.

2.10 Administration and Interpretation of this Certificate

We have sole and exclusive discretion to interpret the Benefits provided under this Certificate as well as all other provisions, terms, conditions, limitations and exclusions in the Certificate and to make factual determinations related to the Certificate and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Certificate. Subject to applicable law or regulation we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate the Certificate, in our sole discretion, without prior notice to or approval by Enrollees. Changes to this Certificate will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.11 Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services must be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

Your responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations for you. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QualChoice National Network (QCNN). QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not responsible for obtaining required pre-authorizations.

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if your clinical status has changed sufficiently that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service department. Any of our pre-authorization decisions may be appealed by following the procedures in Section 7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.12 Utilization Management

We cover Medically Necessary services as described in Section 2.5. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.13 Case Management

We provide a Case Management program. Case Management assists you to make the best use of your Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, high-risk pregnancy, transplants, oncology and neonatology.

2.14 QCARE

QCARE is our population health management program that facilitates access to medical services, and provides tools and self-management assistance to our Enrollees who have chronic medical conditions, such as diabetes, hypertension, and asthma. We work one-on-one with Enrollees to help them understand their illnesses better. We also educate Enrollees on treatment options so that the Enrollee can better manage their health.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this section subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11, and to all other applicable conditions, limitations and exclusions of this Certificate. **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.1 Advanced Diagnostic Imaging

Advanced diagnostic imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of your Certificate as set forth in your Benefits Summary; and
2. Pre-authorization is required for these tests. The requirements for pre-authorization are detailed in Section 2.11 must be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2 Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations as set forth in this Certificate. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in your Benefits Summary, and the following criteria:

1. When an accident or other medical Emergency occurs, we cover transport to the nearest facility when Emergency services are required;
2. We cover ambulance transportation from one facility to another facility for one of the reasons identified below as long as it is coordinated through the QualChoice Care Management department:
    A. To access equipment or expertise necessary to care for you properly;
    B. To receive a test or service which is not available at the facility where you have been admitted and you return after the test or service is completed;
    C. To transport you from an Out-of-Network Facility to a Network Facility; and
    D. To transport you directly from an acute care setting to an alternate level of care.

3.3 Complications of Pregnancy

Coverage is provided for treatment of Complications of Pregnancy when performed or prescribed by a physician subject to the Deductible and Coinsurance amounts specified in the Benefit Summary.

3.4 Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice prior to services being provided. Benefits are subject to a maximum limit per Enrollee per accident. See your Benefits Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery ("D.D.S.") or a Doctor of Medical Dentistry ("D.M.D."). The damage must be severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

The physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth; or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, or no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

If the Enrollee is under age 15, reimbursement for dental care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of QualChoice, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Enrollee is in force when the treatment is rendered.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position; reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5 Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility; and
2. The situation meets Medical Necessity criteria, and the patient is:
    A. A Child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible;
    B. A person with a serious mental health condition that prevents use of local anesthesia for the procedure;
    C. A person with a serious physical condition making facility care necessary for the safe performance of dental work; or
    D. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required (see Section 2.11). **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.6 Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis; and
7. Incision of accessory sinuses, salivary glands or ducts.

3.7 Dental – Other

Other dental care and orthodontic services are not covered.

3.8 Diabetes Management

Diabetes self-management training is limited to one program per lifetime per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9 Durable Medical Equipment

Durable Medical Equipment (DME) is equipment primarily and customarily serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used. DME is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person.

You must obtain all DME through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition of and description of coverage for orthotics and prosthetic devices and services are in Sections 3.22 and 3.27 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a Network DME Provider. It is your responsibility to confirm this with your physician. If DME dispensed by your physician is not from a Network DME Provider, you can obtain a prescription from your physician for the DME and contact us to assist in obtaining the equipment. Failure to insure all DME is obtained from a Network DME Provider will result in denial of Benefits.

3.10 Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section 11.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 11) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United States, are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling the number at the front of this Certificate.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If in an Emergency an Enrollee goes to an Out-of-Network Facility's emergency room for treatment and the Enrollee is admitted at that Out-of-Network Facility for further care or in-patient treatment, *the Enrollee, a family member or the Facility must notify our Care Management Department once the Enrollee is stabilized, but in no event more than forty-eight (48) hours after initial treatment*. Failure to notify us within the specified forty-eight (48) hour time requirement may result in a denial of Benefits. Upon receipt of such notification, we may either authorize the Enrollee's admission to, or further treatment at, the Out-of-Network Provider hospital, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Provider facility, the admitting physician, and the Enrollee's Network Provider. If the Enrollee stays at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the facility and other Out-of-Network Providers providing care to you.

3.11 Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

Benefits also include one routine vision exam, including refraction, to detect vision impairment by a Network Provider once every 24 months. Refraction is only covered when provided in conjunction with a routine vision examination.

Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery and for treatment of disease as specified in Section 4.1.

3.12 Family Planning Services
Coverage is provided for voluntary sterilizations (vasectomies and tubal ligations) except as excluded in Section 4.1

3.13 Home Health Services
Coverage is available for the following services provided in your home when your medical condition supports the need for such services, the services are ordered by a physician, and are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. (See your Benefits Summary for visit limitation details.)

The following services provided by a licensed home health agency in your home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled care, that is, skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse, is not Custodial Care;
2. Physical, occupational and speech therapy services;
3. Medical supplies provided by the home health agency during the course of approved care; and
4. Home services by a nurse midwife, except home deliveries.

3.14 Home Infusion Therapy
The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.
4. When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15 Hospice Services
Hospice services must be pre-authorized and arranged by a QualChoice Case Manager. Consult your Benefits Summary for applicable Cost Sharing Amounts. Coverage is available for Enrollees with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following hospice services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program, provided the hospice program was pre-authorized by QualChoice:

1. In-patient care in a freestanding hospice, a hospice unit within a facility or skilled nursing facility, or in an acute care facility bed; and
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including, but not limited to, the following:
    A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
    B. Respiratory therapy;
    C. Social services;
    D. Nutritional services;
    E. Laboratory examinations;

F. Chemotherapy and radiation therapy when required for control of symptoms;
G. Medical supplies; and
H. Medical care provided by a physician.

3.16 Facility – In-patient Care

In-patient facility care Benefits are available for services and supplies received during the facility stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any facility services unless the service is provided to the Enrollee by an employee of the facility, the facility bills for the service, the service is not primarily for convenience, and the facility retains the payment collected for the service.

Hospital in-patient care is also subject to the following conditions:

1. We cover Medically Necessary acute in-patient facility care for the care or treatment of the Enrollee's condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance.
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy.
4. We do not provide Benefits while an Enrollee is waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
   A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
   B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
   C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred;
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment.

   .
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.11. Please call the number listed on your identification card to notify us of the admission.

3.17 Injectible Prescription Medications

Benefits are available for Injectible Prescription Medication(s) received only when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility based upon the Maximum Allowable Charge for the Injectible Prescription Medication and subject to the applicable Cost Sharing Amounts specified in your Benefits Summary.

3.18 Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19 Maternity Services

The following maternity services are covered as long as the Enrollee has had continuous coverage under her previous group policy and this Certificate combined that is equal to or exceeds any waiting period under the prior group policy:

1. **Fetal Testing:** Amniocentesis or chorionic villus sampling is covered when performed in accordance with recognized standards of care.

2. **In-patient Hospital Stays; Statement of Rights Under the Newborns' and Mothers' Health Protection Act.** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any facility length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

   We will pay for an in-patient facility stay of at least 48 hours for the mother and newborn Child following a normal vaginal delivery. We will pay for an in-patient facility stay of at least 96 hours for the mother and newborn Child following a cesarean section delivery. However, we may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
   Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

   In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact our Customer Service department.
3. **Maternity and Obstetrical Care:** Coverage is provided for Maternity and Obstetrical Care, including routine prenatal care, postnatal care, delivery in an in-patient facility setting, and any related complications. Routine prenatal care includes coverage of only one routine ultrasound usually done between the 16th and 22nd week of pregnancy. If additional ultrasounds are needed due to Medical Necessity, pre-authorization is required. QualChoice provides special prenatal programs designed to benefit you and your baby during pregnancy. These are available at no additional cost and are voluntary. To sign up, you should contact us as early as possible during your pregnancy.
4. **Midwives:** Coverage is provided for services received from a certified nurse midwife, but only if that nurse midwife is a Network Provider and the delivery is done in an in-patient facility setting.
5. **Newborn Care in the Hospital:** A newborn Child of the Certificate Holder or the Certificate Holder's spouse will be covered from the date of birth, including use of newborn nursery and related services, provided the Child's coverage becomes effective on his or her date of birth subject to the requirements of Section 5.0 being met.

3.20 Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a Network Physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds $2,400 per year per person.

The covered amount will be the incurred cost of medical food or low protein modified food products that are in excess of the $2,400 per year per person, subject to the Cost Sharing Amounts specified in your Benefits Summary.

3.21 Medical Supplies

Medical supplies are items that are consumed or reduced with use so that they cannot be repeatedly used, are primarily or customarily used for medical purposes, and are generally not useful in the

absence of an illness or injury. Medical supplies do not include medications or implants. Medical supplies are only covered when prescribed by a physician and when Medically Necessary.

The following conditions will also apply to coverage for Medical supplies:

1. Coverage for medical supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for medical supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used; and
3. Coverage for medical supplies is limited to a 31-day supply per month.

3.22 Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does ***not*** include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.23 Outpatient Services

Outpatient Covered Services are as follows:

1. Outpatient Facility Services: Subject to all of the terms, conditions, limitations and exclusions of this Certificate, Covered Services shall include services provided in a licensed outpatient facility or at a facility outpatient department. Examples include diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for in-patient admission.

2. Outpatient Surgery: Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient facility setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service.

We cover Medically Necessary surgical services. We apply multiple surgical procedures reduction when the same provider performs two or more surgical procedures on the same Enrollee within the same operative session.

3.24 Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefits Summary.

3.25 Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com or you may contact our Customer Service department to obtain specific coverage guidelines.

3.26 Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Certificate and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).
2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;

5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.27 Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.28 Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Certificate.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Enrollee;
2. Surgery performed on a child for the correction of a cleft palate or cleft lip, removal of a port-wine stain (**only** on the face), or correction of a congenital abnormality. In order to be covered, such corrective surgery for a congenital defect must be performed when the child is twelve (12) years or younger, unless, in its sole discretion QualChoice determines that due to the complexity of the procedure, such surgery could not be performed prior to the child's twelfth (12^{th}) birthday. Dental care to correct congenital defects is not a covered benefit;
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery;
4. In connection with a mastectomy eligible for coverage under this Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphademas; or
5. Reduction Mammoplasty that meets our criteria for coverage (which you may request to obtain a copy from us) is a Covered Service subject to Deductible and 50% Coinsurance. Pre-authorization is required.

Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. As further explained in Section 4.1, we do not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services.

3.29 Skilled Nursing Facility and In-patient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute in-patient rehabilitation facility when provided immediately after hospitalization in an acute care general facility for a covered illness or injury. Care will be limited to the number of covered days provided by your Certificate and if Medically Necessary for continued improvement. See your Benefits Summary for details.

3.30 Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a facility. Refer to your Benefits Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.31 Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Certificate. Consult your Benefits Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your QualChoice identification card to obtain pre-authorization before your evaluation for transplant and placement on any transplant list***. Once the evaluation is complete, you must obtain an additional pre-authorization for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the Certificate as follows:

A. **Transplant Covered Services:** We will cover any facility, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us**.
B. **Facility Care:** We cover all in-patient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network Facility, we may require Network Providers at a Network Facility to provide some follow-up care.
C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. This coverage applies to the donor whose organ has been selected to be used in the transplantation. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health plan indicating coverage or denial for the donation.) Please refer to your Benefits Summary for Cost Sharing Amounts and lifetime maximums.

3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   A. Aplastic anemia
   B. Wiscott-Aldrich syndrome
   C. Albers-Schonberg syndrome
   D. Hemoglobinopathy, e.g., Thalassemia major
   E. Myelodysplastic syndromes – primary and acquired
   F. Immunodeficiency syndrome
   G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   I. Neuroblastoma, stage III or IV
   J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   K. Chronic myelogenous leukemia in the chronic phase
   L. Multiple myeloma
   M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse
   N. Chronic Lymphocytic Leukemia
   O. Marrow failure, Fanconi's, red cell aplasia
   P. Amyloidoosis
   Q. Paroxysmal Nocturnal Hemoglobinuria

   This Certificate requires specific donor matches for certain procedures.

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Certificate. Cornea transplantation does not require pre-authorization.

IMPORTANT NOTE REGARDING TRANSPLANTATION SERVICES: It is important that you review and understand the benefit limitations for transplant services described in Section 4.2 of this Certificate.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This section describes those exclusions and limitations. One or more of our optional coverage riders may cover some of these items. If you have purchased riders, they will be provided to you in writing. Please refer to your Benefits Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded

or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1 Non-Covered Services and Exclusions from Coverage

1. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.
2. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted Child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges. For the purpose of this Certificate, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth. Refer to Section 5.1 for information regarding coverage of adopted children.
3. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
4. **Against Medical Advice:** We will not cover any services related to an in-patient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
5. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as the following:
   A. Acupuncture;
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy;
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy; and
   K. Massage Therapy (except as provided for in QualChoice's Medical Policies).
6. **Baby Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
7. **Blood and Blood Donation:** We do not pay for any charges associated with blood donations. We do not pay for procurement, or storage, of donated blood. We do not cover umbilical cord blood banking or blood banking for blood or blood products with unscheduled future use. We do cover the charges for administration of blood and blood products. We do cover blood or blood product banking charges for covered procedures planned in the next 180 days.
8. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
9. **Care Plan Oversight**: Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
10. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
11. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in facilities not licensed as short-term acute care general facility or skilled nursing facilities, for example:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;

D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis facility;
E. Infirmaries at camps or schools;
F. Hospitals for treatment of a Mental Health or Substance Use Disorder;
G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);
H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.29);
I. Extended care, chronic care, or transitional facilities or facilities (except as covered under Section 3.29); or
J. Other facilities and institutions, which do not meet our criteria for short-term acute care general facility or skilled nursing facilities

12. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
13. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year annual treatment limits or lifetime maximums as shown on the Benefits Summary.
14. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
15. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
16. **Chemical Ecology:** Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
17. **Chiropractic Care:** Chiropractic care services are not covered.
18. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
19. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the-counter (without a prescription) are not covered.
20. **Convenience Items or Services:** We will not cover items or services utilized primarily for your convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to, a cot, hot water bottle, telephone, television, television rental charges, whirlpool bath, automobile/van conversion, wheel chair ramp, and home modifications.
21. **Cosmetic or Reconstructive Services**: Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. We will not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services. Procedures or services that change or improve appearance without improving physiological function are also not covered. Procedures or services that correct a physical developmental defect present at the time of birth without improving or restoring physiologic function are considered cosmetic procedures. The fact that an Enrollee may suffer psychological consequences as a result of an injury, sickness or developmental defect present at the time of birth, does not make the service Medically Necessary.
22. **Custodial Care:** We do not cover Custodial Care. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial Care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding, or range of motion exercises. Non-covered Custodial Care may be rendered in a facility, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.

23. **Dental Care:** This Certificate does not provide Benefits for dental care. Except as otherwise stated in this Certificate, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess;
    G. Treatment of dentigerous cysts;
    H. Removal of soft tissue supporting or surrounding teeth;
    I. Orthodontia (including braces);
    J. False teeth;
    K. Orthognathic surgery; or
    L. Any other dental services you may receive, except as specifically set out in your Benefits Summary.
24. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.
25. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.
26. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit, and motor dysfunctions are not covered. Except for an autism screening occurring one time between the ages of 1 and 4, this includes an exclusion for developmental delay associated with autism spectrum disorder.
27. **Dietary and Nutritional Services:** Unless dietary supplies are the sole source of nutrition for the Enrollee (see Section 3.21 - Medical Foods), any services or supplies provided for dietary or nutritional services, including, but not limited to, medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a physician or acquired over-the-counter, are not a covered.
28. **Domestic Partners:** We do not provide coverage for domestic partners of the same sex or opposite sex.
29. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.
30. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
31. **Electronic Consultations:** We do not cover charges for a healthcare provider's consultation by telephone, email, or other electronic communications with you or another healthcare provider.
32. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, are not covered. However, subject to all terms, conditions, exclusion and limitations as set forth in this Certificate; coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.
33. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is not covered. However, subject to all terms, conditions, exclusion and limitations in this Certificate, and at the sole determination of QualChoice, coverage may be provided for enhanced external counterpulsation for the treatment of Enrollees with coronary artery disease documented by coronary artery catheterization. Our Medical Policy regarding enhanced external counterpulsation is available on our website www.qualchoice.com or you may contact our customer service department to obtain specific coverage guidelines.
34. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.
35. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under this Certificate, on grounds of excessive use when it is the determination

of our medical director that: (1) an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia, or by the QualChoice Pharmacy & Therapeutics Committee; or (2) an Enrollee has obtained or attempted to obtain the same medication from more than one physician for the same or overlapping periods of time; or (3) the pattern of prescription medication purchases, changes of physicians or pharmacy, or other information indicates an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider, or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use, or activity to evaluate for excessive use.

36. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a physician.
37. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.
38. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including, but not limited to, plantar fasciitis or tennis elbow, is not covered.
39. **First Aid Supplies:** We will not cover over-the-counter first aid supplies.
40. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, non-surgical care of bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations of this Certificate, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
41. **Foot Orthotics:** Foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.
42. **Fraud or Misrepresentation:** Health interventions or health services, including, but not limited to, medications obtained by unauthorized or fraudulent use of an Enrollee's QualChoice identification card or by material misrepresentation as part of your enrollment process or at other times, are not covered.
43. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you and/or the provider did not think there would be insurance when the provider chose not to charge for the care provided.
44. **Government Programs:** We will not pay for Covered Services to the extent Benefits for such services are payable under Medicare or any other federal, state or local government program.
45. **Group Therapy:** Group therapy or group counseling at any time in any setting by any provider is not covered.
46. **Hair Loss or Growth:** Wigs, hair transplants, or any medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a physician, are not covered

regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.

47. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered. Cochlear implants are the only exception to this exclusion as specified in Section 4.2(4).
48. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.
49. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants, and Nonmyeloalative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.31.
50. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
51. **Illegal Acts:** Except as required by law, we will not cover health care services resulting from participation in a felony, riot, insurrection, or other illegal act, whether or not convicted.
52. **Illegal Uses:** Medications, drugs, or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or accidental injuries from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits are not covered.
53. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury, or prostate surgery.
54. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered.
55. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications, procedures, or other services for treatment of infertility. It does not matter whether the infertility service is diagnostic or therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:
    A. Reversal of sterilization;
    B. Pre-implantation testing;
    C. Surrogate pregnancies;
    D. Medical treatment of infertility;
    E. Surgical treatment of infertility; and
    F. In vitro fertilization

    Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying cause of the infertility are detected or treated during such surgery.
56. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, where the Enrollee is on a cardiac transplant list at a facility where there is an ongoing cardiac transplantation program, the Certificate will cover infusion of inotropic agents.
57. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars, or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.
58. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.

59. **Learning Disabilities:** Services or supplies provided for learning disabilities, for example, reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties, are not covered.
60. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. is not covered.
61. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
62. **Maintenance Therapy:** We will not cover maintenance therapy for physical therapy, occupational therapy, or speech therapy.
63. **Mammoplasty:** Except as provided in Section 3.28, we do not cover mammoplasty for reasons of augmentation or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.
64. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party such as, but not limited to, an employer, licensing board, recreation council, or school.
65. **Marriage and Relationship Counseling:** Marriage and relationship counseling services are not covered.
66. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms or the preparation or copying of medical records.
67. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services, or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications, counseling, weight maintenance programs, gastric stapling, gastric bypass, or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.
68. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including, but not limited to, a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.
69. **Mental Health or Substance Use Disorder:** Services of any kind or nature for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse are not covered. Services that are excluded include, but are not limited to:
    A. Testing, evaluation, assessment and/or treatment of every diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
    B. Hypnotherapy;
    C. Treatment of behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
    D. Hospitalization for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse;
    E. Evaluation of psychosocial factors potentially impacting physical health problems and treatments, including health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems;
    F. Services for treatment of eating disorders are not covered; this exclusion includes treatment for anorexia, bulimia and other eating disorders; and
    G. Family counseling in conjunction with an Enrollee's individual crisis therapy.
70. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of an Enrollee's refusal to comply with a physician's or other provider's

recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.

71. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.
72. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.
73. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.
74. **Over-the-Counter Medications:** Medications (except insulin) which do not by law require a prescription from a physician are not covered.
75. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
76. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
77. **Percutaneous diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.
78. **Percutaneous Kyphoplasty:** Percutaneous kyphoplasty is not covered.
79. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
80. **Performance Enhancement:** We will not cover medical, surgical, or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic, or recreational performance, including, but not limited to, work hardening programs, back schools, programs of general physical conditioning, athletic trainers, and special or specially modified surgical procedures designed to enhance performance above normal.
81. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.
82. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
83. **Pre-existing Conditions:** Benefits for the treatment of a Pre-existing Condition are excluded until you have had continuous coverage under your previous group policy and this Certificate combined for 12 months. This exclusion does not apply to coverage for maternity services for a pregnancy in existence as of the effective date of this Certificate or to an Enrollee under the age of 19.
84. **Pre-Implantation Genetic Diagnosis:** We do not cover pre-implantation genetic diagnosis or treatment.
85. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.
86. **Prescription Drugs:** We do not cover medications prescribed for an Enrollee for use on an outpatient basis, that is, medications not dispensed or administered when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility.
87. **Private Duty Nurses:** We will not cover private duty nurses.
88. **Private Room:** We do not cover a private facility room. We will pay the most common charge for semi-private accommodations. If you are charged for a private room, you must pay the difference between the charges for a private room and our payment.
89. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
90. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
91. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:
    A. Obtaining employment;
    B. Maintaining employment;
    C. Obtaining insurance;
    D. Obtaining professional or other licenses;
    E. Engaging in travel;

F. Athletic or recreational activities; or
G. Attending a school, camp, or other program.

92. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
93. **Rest Cures:** Services or supplies for rest cures are not covered.
94. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
95. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.
96. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental) meeting the definition of a Mental Health or Substance Abuse Disorder.
97. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
98. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Certificate as being a Covered Service.
99. **Services Received Outside the United States:** Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of QualChoice.
100. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
101. **Sexual and Gender Identity Disorders**: Any services related to the treatment of sexual and gender identity disorders are not covered.
102. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome are not covered, except when short stature is caused by laboratory documented growth hormone deficiency.
103. **Sleep Apnea, Portable Studies:** Studies for the diagnosis, assessment, or management of obstructive sleep apnea, not continuously attended by a qualified technician, are not covered.
104. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is included with this Certificate, treatment of caffeine, smoking, or nicotine addiction, smoking cessation prescription medication products, including, but not limited to, nicotine gum and nicotine patches, are not covered.
105. **Snoring:** Devices, procedures, or supplies to treat snoring are not covered.
106. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.
107. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.
108. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Certificate, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical, and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including, but not limited to, the shortening of the mandible or maxillae or the correction of malocclusion.
109. **Thermography:** Thermography, which is the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
110. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or facility or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Certificate prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money

received by the Enrollee from the third party, or its insurer. Please refer to Section 8 and Section 10.8 for further information concerning repayment of Benefits.

111. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
112. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
113. **Trans-telephonic Home Spirometry:** Trans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
114. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for ground or air emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department. Refer to your Benefits Summary for limitations.
115. **Travel, School, Recreation, or Work Related Immunizations:** Except to the extent coverage is specifically provided in this Certificate as a preventive health benefit, we will not cover immunizations to fulfill requirements for international travel, school, recreation, or for work.
116. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.
117. **Vision:** Except as set forth in the Benefits Summary, we will not cover routine eye, services or tests, eyeglasses, contact lenses, and other vision care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes.
118. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglass and contact lenses (except the initial acquisition of one pair within the twelve months following cataract surgery up to $200 for frames and lenses), are not covered.
119. **Vitamins or Supplements:** Vitamins or nutrient supplements not available over the counter are not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism as described in Section 3.21 – Medical Foods.
120. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.
121. **Weight Control:** Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
122. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
123. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition, or disease arising from your employment. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law.
124. **Wound Treatment:** Blood derived growth factors are not covered.

4.2 Limitations to Benefits

Coverage is available for medical services or care as specified in this Section 4.2 subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11, and to all other applicable conditions, limitations and exclusions of this Certificate.

1. **Ambulance:** Transportation by ambulance of any kind is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult your Benefits Summary for benefit limitations.
2. **Auditory Brain Stem Implant.** One auditory brain stem implant per lifetime is covered for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone removal of bilateral acoustic tumors.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Cochlear Implants:** Coverage for cochlear implants is subject to a maximum lifetime benefit of $20,000 per Enrollee. Coverage is limited to one cochlear implant device, the surgical procedure, and one speech processor. Reimplantation of the same device is not covered. Pre-authorization is required.
5. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of facility or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
6. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Out-of Network DME is not covered. Please refer to your Benefits Summary for this annual limit.
7. **Genetic Counseling and Testing:** Genetic testing is generally not covered. Genetic testing is often done on blood or tissue samples sent by your physician to a laboratory. *For genetic counseling or testing to be covered, it requires pre-authorization.* Pre-authorization will only be given in accordance with QualChoice's Medical Policies which require the results of the genetic testing to affect choice of treatment or the outcome of treatment. We will not cover genetic counseling or testing to determine the likelihood of:
    A. Developing a disease or condition; or
    B. Disease or the presence of a disease in a relative; or
    C. Passing an inheritable disease, for example, cystic fibrosis, or congenital abnormality to an offspring.

    However, subject to all terms, conditions, exclusions and limitations set out in this Certificate, genetic testing of the products of an amniocentesis to determine the presence of a disease or congenital anomaly in the fetus or genetic testing of an Enrollee's tissue to determine if the Enrollee has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered if the test meets QualChoice's Medical Necessity criteria. Any approved genetic testing must be preceded by genetic counseling.
8. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Contract Year. The home health care visit limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
9. **Hospice Services:** Hospice services are limited to a maximum number of days of coverage per Enrollee. The hospice services day limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
10. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
11. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.

12. **Lifetime Maximum:** Consult your Benefits Summary and this Certificate for various lifetime maximum Benefits per Enrollee.
13. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Physicians and Network Facilities will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
14. **Medical Supplies:** Coverage of medical supplies is limited to a 31-day supply per month.
15. **Newborn Care:** We will cover Newborn Children of the Certificate Holder or spouse from the date of birth provided the Certificate Holder enrolls the newborn within 90 days after the date of birth.
16. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation, and cardiac rehabilitation services are limited to a maximum number of visits per Enrollee per Contract Year as reflected in your Benefits Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider will not be covered as set out in your Benefits Summary.
17. **Prosthetic and Orthotic Devices and Services.** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.
18. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Physicians for personal reasons. In such case, neither we nor any Network Physician or Provider shall have any further responsibility to provide care for the condition under treatment, unless you later recant the refusal and agree to follow the recommended treatment or procedure.
19. **Shoes and Shoe Inserts:** Custom molded and fitted shoes and shoe inserts are not covered except for an Enrollee with diabetes. Coverage for an Enrollee with diabetes for custom molded and fitted shoes and shoe inserts is subject to the following limitations:
    A. Two (2) pairs of custom molded and fitted shoes per year if the Enrollee is under 18 years of age and one (1) pair of custom molded and fitted shoes for an Enrollee 18 years of age or older; and
    B. Two (2) pairs of custom molded shoe inserts per year.
20. **Transplant Services:** Transplant services are subject to the following benefit maximums and limitations:
    A. Coverage for procurement and testing (per transplant) is limited to the amount reflected in your Benefits Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary ;
    C. We will not cover the transportation and/or lodging costs of the transplant recipient, transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs;
    D. Coverage is limited to no more than the number of transplants per Enrollee per lifetime as reflected in your Benefits Summary. We cover re-transplantation, but a re-transplant is considered a transplant and counts toward the transplant limit;
    E. Expenses for drugs related to avoidance of rejection of a transplanted organ are subject to the lifetime transplant maximum as reflected in your Benefits Summary;
    F. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission, or in complete remission less than two (2) years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small

or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis; and

G. **Transplants that are not pre-authorized by QualChoice Care Management Department are not covered.**

5. ELIGIBILITY CRITERIA

5.1 Who is Eligible for Coverage

Only you and your dependents who were covered under your original employer group policy on the date of termination of coverage under that employer group policy are eligible for coverage under this Certificate. You must list yourself and any of your eligible dependents you are electing to cover on the Enrollment Application to be eligible for coverage. If you do not list them on the Enrollment Application, they will not be eligible for coverage under this Certificate. You and your dependents must meet all eligibility requirements in this Certificate. The following members of your family may be eligible as dependents as long as they were covered under your original employer group policy on the date of termination of coverage under that employer group policy:

1. Your spouse, unless you are divorced or have annulled your marriage. Domestic partners are not eligible for coverage as a dependent under this Certificate.
2. Your Child until s/he becomes twenty-six (26) years of age. However, if your prior employer group policy is a grandfathered plan, your Child nineteen (19) years of age and older but who has not attained the age of twenty-six (26) years is eligible only if s/he is not otherwise eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.
3. Your incapacitated Child may be an eligible dependent. The incapacitated Child must be twenty-six (26) years of age or older and totally disabled due to continuous developmental or physical incapacity. The incapacitated Child must be primarily dependent on you for financial support and you must declare the incapacitated Child as a dependent on your federal income tax returns. The disability leading to mental or physical incapacity must have occurred before the Child reached age twenty-six (26) and while covered under this Certificate or other group medical insurance coverage. The Social Security Administration or a physician must medically certify the disability. In addition to this medical certification, we have the unilateral right to determine whether a Child is, and continues to qualify as an incapacitated Child. At any time, we may request a declaration of disability (or like document) supporting such dependent's incapacity and dependency. You must notify us if the incapacity or dependency is removed or terminated. Newly eligible Enrollees may enroll an incapacitated Child provided the disability commenced before the limiting age and a health benefit plan continuously covered the Child as your dependent since before the limiting age. Our determination of eligibility shall be conclusive.
4. Coverage for a Child whom you have adopted or for whom you have filed a petition for adoption shall begin on the date of the adoption or the date of the filing of the petition for adoption. You must submit an Enrollment Application to us within 60 days after the adoption or the filing of the petition. Coverage will begin subject to payment of all applicable premiums. The coverage shall begin from the moment of birth if the petition for adoption or adoption occurred and you submit the application for coverage to us within 60 days of the birth of the Child. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

Your coverage begins upon the effective date of this Certificate which is the day following your termination of your coverage under the group Certificate. You should contact our Customer Service Department for information concerning your eligibility requirements and effective date. You will not be eligible to enroll if you do not meet the eligibility rules of this Certificate.

Neither you nor your dependent will be eligible to enroll if:

1. You have had previous coverage with us terminated for causes described in Section 5.4(5) of this Certificate.
2. Such person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program.
3. Such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.
4. Such benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.
5. The benefits provided under subparagraph (2) above for such person, or benefits provided or available under the sources referred to in subparagraphs (3) and (4) above for such person, together with the benefits provided by this Certificate, would result in over-insurance according to our standards as filed with Arkansas Insurance Department, if any.
6. If such person is eligible for Medicare.

Coverage for newborn or adopted children in your family begins on the date they meet the eligibility requirements of this Certificate. Coverage for your newborn Child is effective as of the date of birth if you submit an Enrollment Application to us within 90 days of the date of birth of the Child or before the next premium due date, whichever is later. Coverage for your adopted Child is effective as of the date of the adoption if you submit an Enrollment Application to us within 90 days of the date of the adoption of the Child or before the next premium due date, whichever is later.

Coverage, subject to all other terms, conditions, exclusions and limitations of this Certificate, will be extended to an eligible Enrollee who is inpatient in a facility on the effective date of this Certificate. However, consistent with applicable law, if such eligible Enrollee is inpatient in a facility on the effective date of this Certificate and immediately prior to such effective date was covered by a group health plan that provides coverage for facility or medical services or expenses, coverage for benefits under that other group health plan will continue and it will be primarily responsible for those services and expenses associated with that facility admission. As the primary plan, that other group health plan will be responsible for those services and expenses until the end of that facility admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

If your Covered Dependent gives birth, the newborn grandchild is not eligible for coverage. If you, as the Child's grandparent, adopt or become the legal guardian of the Child, we will cover the Child from the effective date of the adoption or the legal guardianship.

5.2 Termination of Coverage

Your coverage under this Certificate will terminate in certain circumstances. We describe these circumstances below.

1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Certificate. Failure to remit premium payments to us in accordance with these terms may result in the suspension of Benefits for you and your Covered Dependents. In the event you do not respond timely to written and verbal demands for payment by us, coverage under this Certificate will be terminated retroactive to the last day of the month for which premium payment was received.
2. **Certificate Holder's Death:** Coverage for Covered Dependents under this Certificate will automatically terminate on the date of the Certificate Holder's death.
3. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.
4. **Termination of Your Marriage:** If you divorce, legally separate, or annul your marriage, the coverage of the Certificate Holder's spouse will automatically **terminate on the date of the** divorce, legal separation, or annulment. A court order requiring the Certificate Holder to provide coverage for the former spouse does not change the termination of coverage.
5. **Termination of Coverage of A Dependent Child:** The coverage of a Child under this Certificate will terminate automatically on the earliest of the following dates on which the Child:
    A. No longer meets the limiting age eligibility requirements;
    B. For a Child incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support; termination of coverage based upon age limitation(s) does not apply to a Child who qualifies as an incapacitated Child.
6. **Our Option to Terminate This Certificate:** We may terminate this Certificate for any of the following reasons:
    A. An Enrollee's intentional misrepresentation of material fact or fraud committed by the Enrollee in connection with any Claim for Benefits filed under this Certificate;
    B. Upon 30 days advance written notice to an Enrollee if he or she persistently fails to cooperate in good faith with the administration of coverage under this Certificate or persistently refuses to comply with treatment plans prescribed by a physician and approved by us;
    C. An Enrollee's coverage for failure to pay any applicable Cost Sharing Amount required under this Certificate upon 30 days advance written notice to such Enrollee unless default in payment is cured within such 30-day period;
    D. Upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's QualChoice identification card or if the Enrollee otherwise cooperates in the unauthorized use of the Enrollee's identification card or Benefits;
    E. Each Enrollee represents all statements made in his or her application for membership, and any applications for membership of dependents, are true to the best of his or her knowledge and belief. If an Enrollee performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, we may void his or her enrollment under this Certificate and the enrollment of his or her covered spouse and dependents. No statement made, for obtaining coverage, will void coverage unless the statement is written in the application and you, the Certificate Holder, signs it;
    F. Failure of an Enrollee to provide information necessary for QualChoice to comply with applicable law, including, but not limited to, the Enrollee's social security number or other government issued identification number;
    G. An Enrollee becomes eligible to enroll in a group health plan or government run health plan and all pre-existing conditions are covered under such group health plan or government run health plan; or
    H. Failure to respond to a request for Recovery of Overpayment in accordance with the provisions of Section 10.8.

QualChoice will notify the affected Enrollee of a decision to terminate the Enrollee's coverage pursuant to the requirements of applicable law. If QualChoice terminates the coverage of an Enrollee, QualChoice shall have no further liability under this Certificate.

7. **Enrollees on Military Leave:** Enrollees (or an Enrollee's Covered Dependent) called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights apply to covered Enrollees and their Covered Dependents immediately before leaving for military service. The following applies to this election:
    A. The maximum period of coverage of a person under such an election shall be the lesser of:
        1. The 24 month period beginning on the date on which the person's absence begins; or
        2. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
    B. A person who elects to continue health plan coverage must pay up to 102% of the full contribution, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
    C. An exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed services.
8. **Hospital Confinement at Time of Termination**: If an Enrollee is facility confined on the date coverage under this Certificate terminates, coverage for such hospitalization will be determined according to the following criteria:
    A. If the Enrollee replaces this Certificate with other coverage, coverage for the Enrollee will continue until facility discharge or Benefits under this Certificate are exhausted, whichever occurs first;
    B. If the Enrollee **does not** replace this Certificate with other coverage, coverage for the Enrollee will cease on the effective date of termination; or
    C. If termination is a result of rescission of coverage by QualChoice, coverage ends on the effective date of such rescission.

    If the hospitalized Enrollee is the Certificate Holder, coverage for any Covered Dependents of this Enrollee ends on the effective date of termination.

6. COORDINATION OF BENEFITS

You and your family members may have coverage under more than one health plan. This Certificate contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1 How COB Works

The order of benefit determination rules govern the order in which each health plan will pay a claim for benefits. The health plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another health plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all health plans do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2 Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary plan coverage:

1. If a health plan does not have a COB provision, that plan is primary.

2. The health plan covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health plan that covers the person as a dependent is secondary.

3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health plan the order of benefits is determined as follows:

A. For a child whose parents are married or are living together, whether or not they have ever been married:

(1) The health plan of the parent whose birthday falls earlier in the calendar year is primary; or

(2) If both parents have the same birthday, the health plan that has covered the parent the longest is primary.

B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);

(2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) Plan of the custodial parent;

(b) Plan of the custodial parent's new spouse (if remarried);

(c) Plan of the non-custodial parent; and then

(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health plan of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The health plan covering that same person as a retired or laid-off employee is secondary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health plan, the health plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health plan does not have this rule, and as a result, the health plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

6. The health plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health plan that covered the person the shorter period of time is secondary.

7. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health plans. In addition, this Certificate will not pay more than it would have paid had it been primary.

6.3 Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan covering

the Enrollee. This means an expense or service not covered by any plan covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans cover you and compute their benefit payments based on that plan's maximum allowable payment, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans and the Allowable Expense is determined by more than one method, the primary plan's payment arrangement shall be the Allowable Expense for all plans.

6.4 Reduction of Benefits

When this Certificate is secondary, we will reduce our benefits so that the total benefits paid or provided by all plans are not more than one hundred percent (100%) of the total Allowable Expense of the primary plan.

A. In determining the amount to be paid for any claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary plan. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total Benefits paid or provided by all health plans for the claim do not exceed the total Allowable Expense of the primary plan for that claim.
B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.
C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5 Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Certificate and other health plans. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Certificate and other health plans covering the person claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under this Certificate. If it does, QualChoice may pay that amount to the other plan that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7 Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8 Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by a group health plan that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary plan for those services and expenses associated with that hospital admission. As the primary plan, that group health plan will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

7. Complaints and Appeals

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of Certificate language, and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and binding on the Enrollee and this Certificate. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

7.1 Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Certificate. Our Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request a Level I Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 9.3 below. An "appeal" must be initiated and conducted as described in Section 9.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Department at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:
   QualChoice
   Attention: Appeals and Grievance Coordinator
   P. O. Box 25610
   Little Rock, Arkansas 72221-5610
4. **Complaint Resolution:** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

7.2 Types of Requests and Claims

1. **Pre-Service Claim:** A Pre-Service Claim is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Certificate.

2. **Post-Service Claims:** Post-Service Claims are those claims for services that have already been received by the Enrollee.
3. **Urgent Care Claim:** An Urgent Care Claim is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:
    A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or
    B. Life, health or ability to regain maximum function could be seriously jeopardized.
4. **Concurrent Care Claim**: A Concurrent Care Claim is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.
6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

7.3 Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Level I Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Claim, Concurrent Care Claim or Urgent Care Claim) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 9. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

    QualChoice
    Attention: Appeals and Grievance Coordinator
    P.O. Box 25610
    Little Rock, AR 72221-5610

2. **Appeal of Pre-Service Claim and Concurrent Care Claim**
    A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee, and respond as soon as possible, but not later than fifteen (15) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
    B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
    C. **Initiating a Pre-Service or Concurrent Care Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing to our Complaint and Appeals Coordinator at the address listed in Subparagraph 1 above.
    D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider have the right to appear in person or attend

via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within fifteen (15) calendar days of the Committee's hearing.

E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within fifteen (15) calendar days from the receipt of the appeal.

F. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Claim or Concurrent Care Claim will be treated as an appeal of an Urgent Care Claim as described in Section 9.3 below subject to the request meeting the criteria for an Urgent Care Claim.

3. **Appeal of Post-Service Claims**

A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer, will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee and respond with a decision as soon as possible, but not later than thirty (30) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **Initiating a Post Service Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing or facsimile to our Complaint and Appeals Coordinator at the address or fax number listed in Subparagraph 1 above.

D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within thirty (30) calendar days of the Committee's hearing.

E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within thirty (30) calendar days from the receipt of the appeal.

F. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Claim**

A. **Initiating a Level I Appeal and Level II Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413.

An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

B. **Level I Appeal and Level II Appeal.** An appeal of an Urgent Care Claim will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review. A medical director different than the one that made the Level I Appeal decision will make the Level II Appeal decision.

7.4 Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Claim as defined in Section 9.2 above can initially be submitted orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Claim appeal even though investigation will have begun.
2. **Right to Information of Enrollee:** We shall provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:
   A. Were relied upon in making the benefit determination;
   B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
   C. Demonstrate compliance with the terms of the Certificate; and
   D. Constitute a statement of policy or guidance with respect to the Certificate concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

   In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Claim or Concurrent Care Claim, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the appeal do not accompany the appeal of a Medical Issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

7.5 Conduct of Appeals

An appeal is conducted following the procedures below:

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.

2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by QualChoice with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

7.6 Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

7.7 Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.
2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.
3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:
    A. An individual designated by the Enrollee in writing in a form approved by us;
    B. The treating provider, if it is a Pre-Service Claim, a Concurrent Care Claim, or an Urgent Care Claim, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
    C. A person holding the Enrollee's durable power of attorney;
    D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
    E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.
4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.
5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

    If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Claim or Concurrent Care Claim, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit

determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

7.8 External Medical Review

After you have exhausted your Level I and Level II appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Claim, please contact QualChoice's Appeal Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in the Certificate, an express limitation in the Certificate, dollar limits under the Certificate, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on both you and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this section. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery

rights under this Section 10 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if you have an injury or illness caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for your Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If you receive payment from a third party or any other insurer for the cost of Covered Services, you are obligated to reimburse us. You may reduce such reimbursement by our pro rata share of reasonable attorney's fees and costs you incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 10. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance as we may reasonably require to fully enforcing the terms of this Section 10. You agree to take no action prejudicing our rights and interests under this Section 10.

9. PRE-EXISTING CONDITIONS

Except as otherwise provided in Subparagraph 9.2 below, no Benefits for services of any kind are provided under this Certificate for treatment of an Enrollee's Pre-existing Condition (as defined in the Section 11) until the Enrollee has had continuous coverage under the previous group policy and this Certificate combined for a period of 12 months from an Enrollee's effective date of coverage under the prior employer group policy. This 12-month period is referred to as the "pre-existing period". If the Enrollee submitted an application for coverage during their initial Waiting Period under the prior employer group policy, the pre-existing period begins on the first day of the Waiting Period. If the Enrollee did not apply for coverage within the Waiting Period, the pre-existing period begins on the Enrollee's original effective date under the prior employer group policy.

9.1 Periods of Creditable Coverage

Periods of Creditable Coverage (as defined in applicable law and regulations) will reduce the Pre-existing Condition exclusion period. For purposes of this Certificate, Creditable Coverage includes the coverage an Enrollee had under the prior employer group policy. The notification an Enrollee receives from us sets out the Enrollee's Pre-existing Condition period as calculated by us. In reaching this determination, we consider Certificates of Creditable Coverage provided by the Enrollee's prior health plans and health insurers as well as information otherwise available to us.

Failure to cooperate fully shall constitute grounds for affirming any original Pre-existing Condition exclusion period determination, and denying Claims on that basis.

9.2 Applicability of Pre-existing Exclusion

This Pre-existing Condition exclusion is not applicable to:

1. Pregnancy if you or your enrolled spouse is pregnant as of the effective date of this Certificate; or
2. An Enrollee under the age of 19.

9.3 Request for Reconsideration of Pre-existing Condition Limitation Period Determination

How to request a reconsideration of a Pre-existing Condition Limitation Period Determination:

1. If an Enrollee disagrees with the Pre-existing Condition limitation period calculated by us, the Enrollee can ask for a reconsideration of this determination by sending a written request to:

   Enrollment Department
   QualChoice
   P.O. Box 25610,
   Little Rock, AR 72221-5610

2. An Enrollee's request for reconsideration must include a written statement of the correct period of time the Enrollee had Creditable Coverage and relevant evidence to corroborate the Enrollee's statement. Relevant evidence can include Certificate(s) of Creditable Coverage issued by prior health plans, explanation of benefits, claims or other correspondence from a health plan

indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a benefit certificate, or the telephone number of the Member's prior heath plan.

3. By requesting reconsideration of the determination of a Pre-existing Condition limitation period, the Enrollee agrees to cooperate with efforts to verify prior coverage. Cooperation includes, but is not limited to, providing written authorization to request a certificate on the Enrollee's behalf from prior health plan(s) and insurer(s), providing information about the Enrollee's prior health plan(s) and insurer(s), such as telephone numbers and addresses, and assisting the efforts to determine the validity of the corroborating relevant evidence.

4. We will make our final determination of an Enrollee's Pre-existing Condition limitation period within a reasonable period of time after it receives the Enrollee's written request for reconsideration.

5. Appeals from a denial of a Claim based on the Pre-existing Condition exclusion (as distinguished from appeals concerning the calculation of the Pre-existing Condition limitation period) should follow the general appeal procedures outlined in Section 9.

10. GENERAL PROVISIONS

10.1 Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under this Certificate. If we do so, we will give thirty (30) days written notice to you and the change will go into effect on the date fixed in the notice.

10.2 Assignment

You cannot assign any Benefits or monies due under this Certificate to any person, corporation, organization or other entity. Any assignment by you will be void and have no effect. Assignment means the transfer of your right to the Benefits provided under this Certificate.

10.3 Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. Notice to us must be in writing and mailed to our offices at:

QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

10.4 Your Medical Records

We may need to obtain copies of your medical records from any of your treating providers. This may be necessary to properly administer your Benefits. You, or your legal representative, agree to sign an appropriate authorization for release of medical records upon our request. If you elect not to consent to the release of medical records, we may be unable to properly administer your coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

10.5 Request for Certificate of Creditable Coverage

You may request from us at any time a Certificate of Creditable Coverage by contacting our Customer Service Department.

10.6 Notice of Claim

We must receive your Claim for Benefits within no more than 12 months from the date you receive the service. Failure to meet this requirement will result in payment denial.

10.7 Who Receives Payment Under This Certificate

We will make payments under this Certificate directly to the Network Providers providing care.

10.8 Recovery of Overpayments
On occasion, an incorrect payment may be made to you. Reasons for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem to you in writing. You must return to us within 60 days the amount of the mistaken payment. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

10.9 Confidentiality
Medical records and other information concerning your care we receive from providers are confidential. We will use such information only to administer your coverage. We will only disclose such information as required to coordinate Benefits or assure continuity of care. Other disclosures require your written consent. See your Notice of Privacy Practices for a more detailed description of your privacy rights and duties.

10.10 Complaint and Appeals
You are entitled to have any complaints heard by us. We are obligated to hear and resolve such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures for complaints and appeals set forth in Section 9 will be followed.

10.11 Right to Develop Policies and Guidelines
We reserve the right to develop or adopt policies and guidelines for the administration of Benefits under this Certificate. These policies and guidelines will be interpretive only and will not be contrary to any terms of this Certificate. If you have a question about the policies or guidelines used to apply to a particular Benefit, you may contact us or visit our website at www.qualchoice.com for further information.

10.12 Limitation on Benefit of This Certificate
No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Certificate. The covenants, undertakings, and agreements set forth in this Certificate shall be solely for the benefit of our Enrollees and us.

10.13 Applicable Law
This Certificate, the rights and obligations of our employees and us under this Certificate, and any claims or disputes relating thereto, shall be governed by and construed in accordance with Federal and Arkansas law.

10.14 Headings
Section and subsection headings contained in this Certificate are inserted for convenience of reference only. They shall not be deemed to be part of this Certificate for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

10.15 Pronouns
All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

10.16 Severability
If any part of any provision of this Certificate or any document or writing given pursuant to or in connection with this Certificate shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Certificate.

10.17 Waiver

The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Certificate shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Certificate or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

11. DEFINITIONS

There are other definitions, usually capitalized, contained in various sections throughout this Certificate. The capitalized words or terms used in this Certificate and are not otherwise defined have the meanings set forth below:

11.1 **"Accidental Injury"** means a bodily injury (other than intentionally self-inflicted injury) happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent of disease or bodily infirmity. Accidental Injury to teeth does not include any damage caused by chewing or biting any object.

11.2 **"Benefits"** means reimbursement or payments for health care available to Enrollees covered under this Certificate.

11.3 **"Benefits Summary"** means a document containing specific information relating to your coverage and Cost Sharing Amounts under this Certificate. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum benefits as well as visit and day maximums for limited services.

11.4 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

11.5 **"Certificate"** means this conversion medical benefits policy through which Benefits are provided, in whole or in part, as reflected in this Certificate.

11.6. **"Certificate Holder"** means you, the person to whom this Certificate is issued.

11.7 **"Child"** means the Certificate Holder's natural child, legally adopted child, child for whom the Certificate Holder is the legal guardian, or stepchild. "Child" also includes a child for whom the Certificate Holder is the adoptive parent during the Waiting Period prior to completing the adoption. Foster children are not included in the definition of "Child".

11.8 **"Claim for Benefits" or "Claim"** means (i) a request for payment or prior approval (when required under the Certificate) for a service, supply, medication, equipment or treatment covered by the Certificate, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee's authorized representative, and (iii) is submitted consistent with QualChoice's standard claim filing policies and procedures (copies of which are available on request).

11.9 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge you must pay toward the cost of certain Covered Services. Those Covered Services subject to the application of Coinsurance are identified in your Benefits Summary. Coinsurance is subject to an annual maximum limit.

11.10 **"Complication of Pregnancy"** means a condition requiring facility confinement, when the pregnancy is not terminated, the diagnosis of which is unrelated to the pregnancy but causes the mother's health to be adversely affected. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity which threaten the mother's health or life.

The following will also be considered a Complication of Pregnancy:

1. A c-section occurring after failure of a trial of labor;

2. An emergency c-section required because of fetal or maternal distress during labor;
3. An ectopic pregnancy which is terminated;
4. A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and
5. A non-scheduled c-section.

11.11 **"Co-payment"** means a fixed dollar amount you must pay each time you receive a particular Covered Service to which a Co-payment applies.

11.12 **"Cost Sharing Amount"** means an amount you are required to pay each time you receive a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in your Benefits Summary.

11.13 **"Covered Dependent"** means any member of the Certificate Holder's family who meets the eligibility requirements of Section 5, who is enrolled in the Certificate, and for whom we have received premium.

11.14 **"Covered Service(s)"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Certificate. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the definition of "Medically Necessary" in this section and the other qualifications set forth in Section 3.

11.15 **"Custodial Care"** means provision of routine care that is primarily for meeting personal needs, including assistance with activities of daily living.

11.16 **"Deductible"** means a certain fixed dollar amount you must incur before we begin to pay for the cost of Covered Services provided to you during each Calendar Year. Each Enrollee must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.

11.17 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

11.18 **"Enrollee"** means a Certificate Holder and any spouse of a Certificate Holder or dependents of the Certificate Holder or of the Certificate Holder's spouse covered under this Certificate.

11.19 **"Enrollment Application"** means the form to be accurately completed by prospective Certificate Holders when they apply for enrollment.

11.20 **"High Dose Chemotherapy"** means Chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., granulocyte, colony-stimulating factor, granulocyte-macrophage colony-stimulating factor, reinfusion of stem cells, reinfusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any Enrollee who received this High Dose Chemotherapy, to prevent life threatening complications of the chemotherapy on the Enrollee's own blood cells.

11.21 **"Injectible Prescription Medications"** means any injectible pharmaceutical that has been approved by the Food and Drug Administration.

11.22 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits

under this Certificate are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much your health care provider may bill for a given service, the Benefits under this Certificate will be limited by the Maximum Allowable Charge we establish. If you use a QualChoice Network Provider and QualChoice is the primary payor, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, **if you use an Out-of-Network Provider you will be responsible for all amounts billed**.

11.23 **"Medical Advisory Committee"** means an internal committee composed of practicing physicians selected by QualChoice from the Arkansas medical community.

11.24 **"Medical Policy" or "Medical Policies"** means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit certificate or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

11.25 **"Medically Necessary" or "Medical Necessity"** means a Covered Service, which in the opinion of our medical personnel:

A. Provides for the diagnosis or treatment of the Enrollee's covered medical condition;
B. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's illness, injury or medical condition in relation to any overall medical/health conditions;
C. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
D. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
E. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

11.26 **"Mental Health or Substance Use Disorder"** means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & Statistical Manual of Mental Diseases of the American Psychiatric Association (DSM) classification.

11.27 **"Network Facility"** means a hospital facility or other facility (e.g., hospice, ambulatory surgery center, etc.) that has entered into an agreement with us to make Covered Services available to Enrollees.

11.28 **"Network Primary Care Physician"** means a physician who has entered into an agreement with us regarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilized by an Enrollee as his or her primary care physician. The following will be considered to be a primary care physician: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

11.29 **"Network Provider"** means a Network Primary Care Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

11.30 **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with us regarding, among other things, willingness to provide specialty Covered Services to Enrollees and who may be utilized by an Enrollee as his or her specialty physician. The following will not be considered to be a specialist: (a)

Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

11.31 **"Out-of-Network Provider"** means a physician, facility or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees. Regardless of any other provision in this Certificate, the extent of QualChoice's coverage for services provided by an Out-of-Network Provider is as set forth in your Benefits Summary.

11.32 **"Out-of-Pocket Limit"** means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

11.33 **"Pre-existing Condition"** means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on (1) the Member's effective date with the Certificate or (2) the first day of their Waiting Period, as applicable. The period is calculated by counting back from the first day of the Waiting Period, rather than from the Member's actual effective date. If the Member does not apply within the Waiting Period, the 6-month period is calculated by counting back from the Member's effective date of coverage.

Notwithstanding the definition above, with respect ONLY to an Enrollee who is under nineteen (19) years of age, "Pre-existing Condition" means a condition that was present before the effective date of coverage, or if coverage is denied, the date of the denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.

A preexisting condition can be identified through information relating to health status before the Enrollee's effective date of coverage or if coverage is denied, the date of the denial, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the Enrollee, or review of medical records relating to the pre-enrollment period.

Moreover, the definition above does not include an Enrollee's pregnancy in existence on the effective date of this Certificate.

11.34 **"Referral"** means a specific written approval from us that an Enrollee seeks for additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Certificate. We issue Referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you are completed during the appropriate period. There will be no coverage for services rendered outside the approved period.

11.35 **"Service Area"** means the geographical area in which we are licensed by the State of Arkansas to conduct business.

11.36 **"Waiting Period"** means the period from your date of hire until the date you were first eligible for coverage under your employer group policy.

Michael E. Stock

Michael E. Stock, President & CEO
QCA Health Plan, Inc.
The QualChoice Building
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Rate Information

Rate data applies to filing.

Filing Method:

Rate Change Type: Increase

Overall Percentage of Last Rate Revision: %

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
QCA Health Plan, Inc.	Increase	%	%				%	%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:	112							112
Policy Holders:	112							112

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Rate Review Details

COMPANY:

Company Name:	QCA Health Plan, Inc.
HHS Issuer Id:	95448
Product Names:	QCA Conversion Evidence of Coverage
Trend Factors:	

FORMS:

New Policy Forms:	QCA Conversion (8-11)
Affected Forms:	
Other Affected Forms:	QCA HMO (01-01-05) Amended Conversion

REQUESTED RATE CHANGE INFORMATION:

Change Period:	Other
Member Months:	450
Benefit Change:	Increase
Percent Change Requested:	Min: 9.9 Max: 9.9 Avg: 9.9

PRIOR RATE:

Total Earned Premium:	190,634.00
Total Incurred Claims:	215,536.00
Annual $:	Min: 423.63 Max: 423.63 Avg: 423.63

REQUESTED RATE:

Projected Earned Premium:	215,040.00
Projected Incurred Claims:	220,123.00
Annual $:	Min: 448.00 Max: 448.00 Avg: 448.00

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved-Closed 07/28/2011	QCA Conversion Rate Summary Eff Aug 2011	QCA Conversion (8-11) and QCA HMO (01-01-05) Amended Conversion	Revised	Previous State Filing Number: Percent Rate Change Request:	QCA Conversion Rate Summary Eff Aug 2011 Revised.pdf

QCA HEALTH PLAN, INC. GROUP CONVERSION RATES FOR FORM NUMBER

QCA HMO (01-01-05) AMENDED CONVERSION

EFFECTIVE AUGUST 1, 2011

Single: $450.59

Family: $1,173.73

Summary of Benefit Design

Deductible	$500
Coinsurance	80%
Coinsurance Maximum	$2,000
Physician Services❖	
PCP Office Visit	$20 copay
Specialist Office Visit	$35 copay
Surgical	Ded/coinsurance
Inpatient Medical	Ded/coinsurance
Outpatient Services❖	Ded/coinsurance
PT & OT (20 visits/yr)	$20 copay
ST (10 visits/yr)	$20 copay
Inpatient Services❖	
Room & Board	Ded/coinsurance
Prescriptions Drugs	Not covered

❖**IMPORTANT NOTE:** There are no benefits for services provided by a healthcare provider who is not a participating provider in the QualChoice Network. You may find out whether a healthcare provider is a QualChoice participating provider by searching the directory on our website at www.qualchoice.com or by calling our Customer Service Department at (800) 235-7111.

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/28/2011

Comments:

This certifies that the QCA Conversion Evidence of Coverage Certificate (Form # QCA Conversion (8-11)) and QCA Amendment to Conversion Evidence of Coverage (Form # QCA HMO (01-01-05)) do not meet the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. § 23-80-206. Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. § 23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	07/28/2011

Comments:

Please see attached.

Attachment:

Application for Conversion Policy_AID August 2011.pdf

		Item Status:	Status Date:
Satisfied - Item:	Health - Actuarial Justification	Approved-Closed	07/28/2011

Comments:

Please see attached.

Attachment:

QCA Conversion Policy Actuarial Memorandum August 2011 Revised.pdf

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	07/28/2011

Comments:

There are attached a benefits summary for both grandfathered members who were effective prior to March 23, 2010 and non-grandfathered who were (or will be) effective after March 23, 2010.

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Attachments:

QCA Non-GR Conversion Benefit Summary Aug 2011.pdf

QCA Grandfather Conversion Benefit Summary Aug 2011.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved-Closed	07/28/2011

Comments:

Please see attached.

Attachment:

QCA Conversion PPACA Compliance Summary.pdf

APPLICATION FOR CONVERSION POLICY

Complete all sections in BLUE or BLACK INK and sign. This application must be received by QualChoice within 30 calendar days of the loss of your group coverage.

SECTION I. PERSON APPLYING FOR COVERAGE

Name (Last, First, Middle)			
Mailing Address	**City/State/Zip**		
County	**Home Phone No.**	**Marital Status**	
		Date of Status Change:	**Please Check One:**
		_____/_____/_____	☐ Single ☐ Married ☐ Divorced ☐ Widowed
Coverage Desired (Please Check One):		**Do all applicants live in Arkansas?**	
☐ Single ☐ Family		☐ Yes ☐ No	

COMPLETE THE FOLLOWING FOR ALL PERSONS APPLYING:

Name *(Last, First, Middle)*	Gender	Relationship to Applicant	Social Security No. / Date of Birth	Primary Care Physician (if applicable)
	☐ Male ☐ Female	Self	___-___-____ Date of Birth: _____/_____/_____	
	☐ Male ☐ Female	Spouse	___-___-____ Date of Birth: _____/_____/_____	
	☐ Male ☐ Female	Child(ren)	___-___-____ Date of Birth: _____/_____/_____	
	☐ Male ☐ Female		___-___-____ Date of Birth: _____/_____/_____	
	☐ Male ☐ Female		___-___-____ Date of Birth: _____/_____/_____	

SECTION II. PRIOR INSURANCE COVERAGE

Date of Termination of Group Coverage	Name of Previous Employer	I.D. No.	Group No.
_____/_____/_____			

SECTION III. ELIGIBILITY FOR OTHER COVERAGE

A. Are you, or any dependent, proposed to be covered by this policy eligible for coverage under any other group accident and health policy? This would include being eligible to elect COBRA, state continuation and/or coverage under a spouse's employer's group coverage.

☐ **Yes** ☐ **No** If **YES**, please list names below.

Last Name	First Name	MI

12615 CHENAL PKWY, STE. 300 ■ LITTLE ROCK, AR 72211 ■ (P) 501.228.7111 ■ 800.235.7111 ■ WWW.QUALCHOICE.COM

B. Are you, or any dependent, proposed to be covered by this policy also eligible for/or covered by Medicare?

☐ **Yes** ☐ **No** If **YES**, Effective Date: _____/_____/_____. If **YES, please** list below dependents who are eligible for/or covered by Medicare.

Last Name	First Name	MI

SECTION IV. UNDERSTANDINGS, REPRESENTATIONS AND AGREEMENTS
(PLEASE READ BEFORE SIGNING IN INK)

In signing below:

(1) *I understand that this application is subject to approval by QCA Health Plan, Inc. The Contract to be issued (including any Attachments) constitutes the entire agreement between the parties hereto with respect to the subject matter hereof, and supersedes all prior oral or written agreements, commitments, or understanding with respect to the matters provided for herein. The Contract, the rights and obligations of the parties hereto, and any claims or disputes relating thereof, shall be governed by and construed in accordance with the laws of the state of Arkansas (but not including the choice of laws rules thereof).*

(2) *I represent that the statements and answers given in this application (or any attachment hereto) are true, complete and correctly recorded to the best of my knowledge and belief.*

(3) *I authorize any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company having Protected Health Information (PHI) with respect to any physical or mental condition or treatment on me or any member of my family (if applicable), to give QualChoice, its respective agents, affiliates, reinsurers, appropriate reporting agencies or legal representatives any and all such information to use for underwriting or claims purposes.*

(4) *I understand that coverage may be denied if authorization is not given to obtain any additional PHI.*

(5) *I understand that if coverage is approved, the PHI received will become a part of my record with QualChoice and QualChoice will not use, disclose or retain the PHI except as required or authorized by law. I agree that a photocopy of this authorization shall be as valid as the original. I understand that a copy is available to me upon request.*

(6) *I understand that any fraudulent statement, omission, or intentional material misrepresentation may result in coverage being terminated or rescinded (voided), including dependent coverage, issued in reliance thereon, and that QualChoice may recover any monies and damages incidental and consequential that result.*

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE. This application must be signed in the state of Arkansas.

This application was signed in _____, Arkansas.
City

Signature of Applicant	Date Signed
X	
Signature of Spouse	**Date Signed**
X	
Parent/Guardian Signature (if policy for a minor)	**Date Signed**
X	

SECTION V. INSTRUCTIONS

Please fax or mail completed form to:

QualChoice
ATTN: Enrollment Department
PO Box 25610 ■ Little Rock, AR 72221
Fax: 501.707.6805

THIS APPLICATION MUST BE RECEIVED BY QUALCHOICE WITHIN THIRTY (30) CALENDAR DAYS OF THE LOSS OF YOUR GROUP COVERAGE

This benefit summary is part of the Conversion Evidence of Coverage (EOC) (Form # QCA POS Conversion (8-11)) and Amendment to Conversion Evidence of Coverage (Form # QCA HMO (01-01-05) Amended Conversion) and subject to all benefit terms and conditions, limitations and exclusions included in the Conversion Evidence of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon soley to determine coverage. Please refer to the Conversion Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Conversion Evidence of Coverage is different than this benefit summary, the Conversion Evidence of Coverage prevails.

Some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit our website at www.qualchoice.com.

All benefit payments are based on the QualChoice Maximum Allowable Charge. Use of an Out-of-Network Provider will result in you being responsible for the full cost of services. Amounts in excess of the QualChoice Maximum Allowable Charge do not count toward annual Deductible or Coinsurance limits. See the "Member Financial Responsibility Comparison" section in the Conversion Evidence of Coverage.

Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ Each covered member is responsible for meeting his/her deductible. ▪ Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year ▪ The annual Deductible is calculated on a Calendar Year basis	Individual: $500	Not Covered
Annual Out-of-Pocket Limit ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the individual annual Coinsurance limit is satisfied for each covered family member ▪ Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	Individual: $2,000	Not Covered
Coinsurance	20% after Deductible	Not Covered
Preventive Care Services (Performed in the Office):		
QualChoice preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved QualChoice medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and QualChoice medical policies.		
Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).*	Paid in Full	
Well baby care, birth - to age 2	No Cost to You	Not Covered
Well child care, ages 2-18	No Cost to You	Not Covered
Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	No Cost to You	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually	No Cost to You	Not Covered
▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	No Cost to You	Not Covered
Smoking cessation	Not Covered	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	$20 Co-payment	Not Covered
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	$35 Co-payment	Not Covered
Professional services that are subject to Deductible and Coinsurance (in addition to the office Co-payment) ▪ Complex diagnostic services, such as advanced imaging (CT, MRI, MRA, Nuclear Medicine), DEXA, Treadmill tests ▪ Other procedures, such as chemotherapy, radiation and infusion therapy ▪ Complex Injectible Prescription Medications which include: All specialty medications such as enbrel, humira, IV medications and high potency antibiotics ▪ Complex procedures such as cystoscopy, colposcopy and invasive biopsies ▪ Services and procedures provided by a physician in a facility	PCP: $20 Co-payment or Specialist: $35 Co-payment and 20% after Deductible	Not Covered
Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year)	20% after Deductible	Not Covered
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Home Health Care (40 visits per Calendar Year)	20% after Deductible	Not Covered
▪ Outpatient Surgical Services		
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	20% after Deductible	20% after Deductible
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	20% after Deductible	20% after Deductible
Therapy Services		
▪ Physical Therapy/Occupational Therapy (20 visit calendar year limit) ▪ Speech Therapy (10 visit calendar year limit) ▪ Cardiac Rehabilitation (36 visits per Calendar Year)	$35 Co-payment	Not Covered
Maternity Services - only available if member was pregnant at time of conversion plan enrollment		
Physician Services ▪ Routine Prenatal Lab	Paid in full	Not Covered
▪ Initial Office Visit	$20 Co-payment	
▪ All other services	20% after Deductible	
Facility Services	20% after Deductible	Not Covered
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	20% after Deductible	Not Covered

Mental Health and Substance Use Disorder Services	**In-Network (You Pay)**	**Out-of-Network (You Pay)**
▪ Inpatient Hospital Services (10 day limit/calendar year)	20% after Deductible	Not Covered
▪ Professional Services (Office/**Outpatient Visits**)-10 visit limit/calendar year	$35 Co-payment	
▪ Professional Services (Inpatient/**Outpatient** Facility)	20% after Deductible	
Allergy Services		
▪ Office Visit and Allergy Testing	PCP: $20 Co-payment or Specialist: $35 Co-payment	Not Covered
▪ Allergy Shots	Paid in Full	Not Covered
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $2,000 maximum benefit per Calendar Year	20% after Deductible	Not Covered
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	20% after Deductible	Not Covered
▪ Provided in connection with home infusion therapy	20% after Deductible	
▪ Provided in connection with Durable Medical Equipment	20% after Deductible	
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.*	20% after Deductible	Not Covered
Reconstructive Surgery ▪ Breast reconstruction following mastectomy ▪ Restoration due to acute trauma, infection or cancer *Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.*	20% after Deductible	Not Covered
Transplantation Services ▪ Physician/Professional charges	20% after Deductible	Not Covered
▪ Inpatient and Outpatient Charges *Note: Lifetime maximum of two transplants*	20% after Deductible	
Diabetes Management Services ▪ Insulin Pumps ($5,500 benefit maximum per Calendar Year)	20% after Deductible	Not Covered
▪ Supplies and equipment (Subject to $2,000 DME limit)	20% after Deductible	
▪ Diabetic Education (1 training per lifetime)	$35 Co-payment	
Dental Care ▪ Accidental injury to sound and natural teeth $2,000 maximum benefit per accident	20% after Deductible	Not Covered
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	20% after Deductible	Not Covered
Genetic Counseling and Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized 20% after Deductible	Not Covered
Prescription Drugs	Not Covered	Not Covered

This benefit summary is part of the Conversion Evidence of Coverage (EOC) (Form # QCA POS Conversion (8-11)) and Amendment to Conversion Evidence of Coverage (Form # QCA HMO (01-01-05) Amended Conversion) and subject to all benefit terms and conditions, limitations and exclusions included in the Conversion Evidence of Coverage. This benefit summary is intended only to highlight your benefits and should not be relied upon soley to determine coverage. Please refer to the Conversion Evidence of Coverage for a complete listing of services, limitations, exclusions and a description of all the terms and conditions of coverage. In the event the language in the Conversion Evidence of Coverage is different than this benefit summary, the Conversion Evidence of Coverage prevails.

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Medical Benefits and Covered Services	In-Network (You Pay)	Out-of-Network (You Pay)
Annual Deductible ▪ Co-payments are not included in the annual Deductible ▪ Each covered member is responsible for meeting his/her deductible. ▪ Deductible amounts applied in the last quarter of a Calendar Year will not carry over to the next Calendar Year ▪ The annual Deductible is calculated on a Calendar Year basis	Individual: $500	Not Covered
Annual Out-of-Pocket Limit ▪ Benefits will be paid at 100% of the Maximum Allowable Charge once the individual annual Coinsurance limit is satisfied for each covered family member ▪ Co-payments do not apply toward your Out-of-Pocket Limit. You will continue to be responsible for Co-payments once the Out-of-Pocket Limit is reached ▪ Out-of-Pocket Limit & benefit limits are calculated on a Calendar Year basis	Individual: $2,000	Not Covered
Coinsurance	20% after Deductible	Not Covered
Preventive Care Services (Performed in the Office):		
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Immunizations, including flu and pneumonia vaccines **Child Immunizations (age 0-18)** **Adult Immunizations (age 18+)** ▪ Diphtheria and Tetanus toxoid for ages over seven (Td), every 10 years ▪ Hepatitis B (Hep B) - once per lifetime ▪ Influenza, annually ▪ Pneumococcal Conjugate, adult over 55 or immunosuppressed ▪ Zoster, adult 60 and older ▪ HPV (covered age 9-18, females only) *Note: Immunizations for travel, school, work or recreation are not covered. See the "Physician Office Services" section in the Evidence of Coverage (EOC).*	Paid in Full	
Well baby care, birth - to age 2	$20 Co-payment	Not Covered
Well child care, ages 2-18	$20 Co-payment	Not Covered
Other preventive services ▪ Annual physical ▪ Pap smear ▪ Screening mammogram (including breast exam) age 40 and over ▪ Prostate screenings for men age 40 and over	$20 Co-payment	Not Covered

Preventive Care Services, continued	In-Network (You Pay)	Out-of-Network (You Pay)
Other preventive services, continued ▪ Bone density screening tests, preventive for women age 65+ ▪ Fecal occult blood test annually	20% after Deductible	Not Covered
▪ Flexible sigmoidoscopy once every 5 years; OR ▪ Double contrast barium enema once every 5 years; OR ▪ Preventive colonoscopy age 50 and older, once every 10 years	20% after Deductible	Not Covered
Smoking cessation	Not Covered	Not Covered
Professional Services		
Primary Care Physician (PCP) Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures ▪ Routine Injectible Prescription Medications which include: 1st generation antibiotics, topical and local anesthesia, steroid, hormone and vitamin injections	$20 Co-payment	Not Covered
Specialist Office Visit ▪ Evaluation and management services ▪ Routine diagnostic services - lab & x-ray ▪ Routine procedures, such as skin biopsy, shaving benign lesions and closures	$35 Co-payment	Not Covered
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Inpatient Care - Room and Board		
▪ Inpatient care - room and board ▪ Skilled Nursing Facility and Inpatient Rehabilitation Services (combined 30 day limit per Calendar Year)	20% after Deductible	Not Covered
Outpatient Care and Ambulatory Care Centers		
▪ Outpatient Care and Ambulatory Care Centers ▪ Observation Services ▪ Diagnostic Services - Advanced imaging, Lab & X-Ray ▪ Hospice services (limited to a lifetime maximum of 180 days) ▪ Home Health Care (40 visits per Calendar Year)	20% after Deductible	Not Covered
▪ Outpatient Surgical Services	20% after Deductible	
Emergency Services		
▪ Emergency Room, Urgent Care or ER Observation Services	20% after Deductible	20% after Deductible
Transportation Services		
▪ Ambulance - Ground or Air ($1,000 maximum benefit per Calendar Year) *Note: Facility to facility ambulance transfer requires pre-authorization.*	20% after Deductible	20% after Deductible
Therapy Services		
▪ Physical Therapy/Occupational Therapy (20 visit calendar year limit) ▪ Speech Therapy (10 visit calendar year limit) ▪ Cardiac Rehabilitation (36 visits per Calendar Year)	$35 Co-payment	Not Covered
Maternity Services - only available if member was pregnant at time of conversion plan enrollment		
Physician Services ▪ Routine Prenatal Lab	Paid in full	Not Covered
▪ Initial Office Visit	$20 Co-payment	
▪ All other services	20% after Deductible	
Facility Services	20% after Deductible	Not Covered
Infertility Diagnostic Services Only *Note: Treatment of infertility is not covered.*	20% after Deductible	Not Covered

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▪ Professional Services (Office/**Outpatient Visits**)-10 visit limit/calendar year	$35 Co-payment	
▪ Professional Services (Inpatient/**Outpatient** Facility)	20% after Deductible	
Allergy Services		
▪ Office Visit and Allergy Testing	PCP: $20 Co-payment or Specialist: $35 Co-payment	Not Covered
▪ Allergy Shots	Paid in Full	Not Covered
Other Treatment, Services and Supplies		
Durable Medical Equipment (DME) ▪ $2,000 maximum benefit per Calendar Year	20% after Deductible	Not Covered
Medical Supplies ▪ Provided in physician's office; if it is in conjunction with an office surgery it is not paid separately.	20% after Deductible	Not Covered
▪ Provided in connection with home infusion therapy	20% after Deductible	
▪ Provided in connection with Durable Medical Equipment	20% after Deductible	
Prosthetic and Orthotic Services and Devices ▪ Prosthetic Services and Prosthetic Devices ▪ Orthotic Services and Orthotic Devices *Note: QualChoice does not cover replacement or associated services more frequently than (1) time every three years unless Medically Necessary. See your Evidence of Coverage for more information.*	20% after Deductible	Not Covered
Reconstructive Surgery ▪ Breast reconstruction following mastectomy ▪ Restoration due to acute trauma, infection or cancer *Note: These benefits are for physician/professional charges. For benefits related to these services for Inpatient or Outpatient charges, see Inpatient or Outpatient sections on page 2.*	20% after Deductible	Not Covered
Transplantation Services ▪ Physician/Professional charges	20% after Deductible	Not Covered
▪ Inpatient and Outpatient Charges *Note: Lifetime maximum of two transplants*	20% after Deductible	
Diabetes Management Services ▪ Insulin Pumps ($5,500 benefit maximum per Calendar Year)	20% after Deductible	Not Covered
▪ Supplies and equipment (Subject to $2,000 DME limit)	20% after Deductible	
▪ Diabetic Education (1 training per lifetime)	$35 Co-payment	
Dental Care ▪ Accidental injury to sound and natural teeth $2,000 maximum benefit per accident	20% after Deductible	Not Covered
Medical Foods for Phenylketonuria ▪ Benefits available after member has paid $2,400 per year	20% after Deductible	Not Covered
Genetic Counseling and Testing *Note: Genetic testing is typically not covered, except in rare situations. When covered, these tests are subject to Deductible and Coinsurance. Talk with your physician. If genetic testing is done and there is no pre-authorization, you will be responsible for the charges. See medical policies at www.qualchoice.com for more information.*	No benefits if not pre-authorized 20% after Deductible	Not Covered
Prescription Drugs	Not Covered	Not Covered

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☑ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☐ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
QCA Health Plan, Inc.	95448	QUAC-127331254	QCA Conversion (8-11) **and** QCA HMO (01-01-05) Amended Conversion	☑ Yes ☐ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Pg. 30 (Exclusion #84); Pg. 47, Sec. 9.2; Pg. 53, Sec. 11.33			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: There are no overall annual dollar limits placed on essential benefits in the policy.			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: There are no lifetime dollar limits placed on essential benefits in the policy.			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number: Pg 37, Sec. 5.2(6)			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Medical Benefits Summary, Pages 1-2			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Pg 35, Sec. 5.1(2)			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number: Pg. 45, Sec. 7.8			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no,** please explain.
	Explanation: No requirement of the plan to obtain prior authorization for emergency services.			
	Page Number: Pg. 15, Sec. 3.10			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: No requirement to select PCP for child.			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☑ **Yes** ☐ No If **no**, please explain.
	Explanation: No prohibition in plan for seeking services of Ob/Gyn without referral.			
	Page Number:			

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PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

SERFF Tracking Number:	*QUAC-127331254*	*State:*	*Arkansas*
Filing Company:	*QCA Health Plan, Inc.*	*State Tracking Number:*	*49356*
Company Tracking Number:			
TOI:	*H06 Health - Conversion*	*Sub-TOI:*	*H06.000 Health - Conversion*
Product Name:	*QCA Conversion Policy Eff August 2011*		
Project Name/Number:	*/*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/28/2011	Form	Amendment to Conversion Evidence of Coverage	07/28/2011	QCA Conversion Amendment Aug 2011 Revised Final.pdf (Superceded)
07/20/2011	Form	Amendment to Conversion Evidence of Coverage	07/28/2011	QCA Amendment To Conversion Aug 2011.pdf (Superceded)
07/20/2011	Rate and Rule	QCA Conversion Rate Summary Eff Aug 2011	07/28/2011	QCA Conversion Rate Summary Eff Aug 2011.pdf (Superceded)
07/20/2011	Supporting Document	Health - Actuarial Justification	07/28/2011	QCA Conversion Policy Actuarial Memorandum August 2011.pdf (Superceded)

QCA HEALTH PLAN, INC. GROUP CONVERSION RATES FOR FORM NUMBERS

QCA CONVERSION (8-11) AND QCA HMO (01-01-05) AMENDED CONVERSION

EFFECTIVE AUGUST 1, 2011

Single: $450.59

Family: $1,173.73

Summary of Benefit Design

Deductible	$500
Coinsurance	80%
Coinsurance Maximum	$2,000
Physician Services	
PCP Office Visit	$20 copay
Specialist Office Visit	$35 copay
Surgical	Ded/coinsurance
Inpatient Medical	Ded/coinsurance
Outpatient Services	Ded/coinsurance
PT & OT (20 visits/yr)	$20 copay
ST (10 visits/yr)	$20 copay
Inpatient Services	
Room & Board	Ded/coinsurance
Prescriptions Drugs	Not covered

Amendment to Conversion Evidence of Coverage (Form # QCA HMO (01-01-05))

Attached is the Benefits Summary indicating name, benefits, Out-of-Pocket Limit amount, type of coverage, Preexisting Condition exclusion period, and effective date.

IMPORTANT NOTICE

COVERED SERVICES RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN VERY LIMITED CIRCUMSTANCES AS SET FORTH IN YOUR BENEFITS SUMMARY ARE NOT COVERED. REFER TO YOUR BENEFITS SUMMARY.

THIS COVERAGE CONTAINS A PREEXISTING CONDITION LIMITATION. REFER TO THE BENEFITS SUMMARY.

The benefits in this Certificate do not necessarily equal or match those benefits provided in your previous group policy.

Underwritten by:
QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
www.qualchoice.com

IMPORTANT QUALCHOICE CONTACT INFORMATION

QualChoice is committed to providing better customer support. That includes making it easy for you to contact us. You are always welcome to call us with any questions or concerns.

Website Address:

www.qualchoice.com

Our Customer Service Department can be reached:

Toll Free at (800) 235-7111

Locally at (501) 228-7111

Our QCARE Coaches can be reached:

Toll Free at (888) 795-6810

Our "Ask a Nurse" assistance line can be reached:

Toll Free at (866) 232-0447

TABLE OF CONTENTS

1. INTRODUCTION TO YOUR AMENDED CERTIFICATE

1.1. Certificate

QCA Health Plan, Inc. Inc. ("QualChoice" also referred to as "us", "we" or "our") is a licensed Health Maintenance Organization. QualChoice has a certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone number is (501) 228-7111 or toll free (800) 235-7111.

This is your Amendment to the Conversion Evidence of Coverage Certificate (Form # QCA HMO (01-01-05)) (the "EOC"). The Amendment modifies the EOC as set forth in herein. To the extent there is conflict between this Amendment and the EOC, this Amendment will control. This Amendment shall be referred to hereinafter as the "Certificate".

This Certificate is a legal document between QCA Health Plan, Inc. and you to provide Covered Services subject to the terms, conditions, exclusions and limitations included herein.

1.2. Changes to This Certificate

We may from time to time modify this Certificate through a "Rider" and/or "Amendment" that may change certain provisions of this Certificate. When this happens we will send you a new Certificate, Rider or Amendment.

1.3. Key Information

For purposes of this Certificate, "you" or "your" means the Certificate Holder.

Only we have the right to change, interpret, modify, withdraw or add Benefits, or terminate this contract, as permitted by law, without your approval.

On its effective date, this Certificate replaces and overrules any certificate that we may have previously issued to you. This Certificate will in turn be overruled by any certificate we issue to you in the future.

Your coverage under this Certificate begins at 12:01 a.m. on the effective date, which is the day following the termination of your coverage under the employer group policy. We will continue your coverage unless and until you or we terminate it for any of the reasons described in this Certificate. We determine your eligibility for Benefits under this Certificate.

This Certificate and Benefits Summary describe your Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The Benefits Summary provided to you is an integral part of this Certificate. In the event this Certificate and the Benefits Summary conflict, the Benefits Summary will control. You should locate and familiarize yourself with the Benefits Summary.

This Certificate describes some special procedures with which you must comply.

To the extent that state law applies, the laws of the State of Arkansas shall govern this Certificate.

We have capitalized certain words in this Certificate. Those words have special meanings and, unless defined otherwise elsewhere, are defined in Section 11, "Definitions".

2. HOW THIS PLAN WORKS

This Certificate provides you with a flexible choice in selecting options in obtaining health care services and how your choice may financially impact you. We encourage you to utilize a Network Primary Care Physician to assist in the coordination of your health care services under this Certificate. The utilization of a Network Primary Care Physician is a matter you control and you are not required to notify us of your Network Primary Care Physician relationship. You are always encouraged to seek care directly from a Network Primary Care Physician first. You may also seek care with any Network Physician or Provider under this Plan without a Referral. Consult your Benefits Summary to identify Covered Services and Cost Sharing amounts.

2.1 In-Network Benefits

In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider or at a Network Facility; or
2. Emergency health services meeting the QualChoice payment guidelines.

Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and meets either of these requirements will be processed as an In-Network Benefit. Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and does not meet either of these requirements will not be covered.

You should validate the status of a Network Provider by accessing the on-line directory at any time or calling Customer Service during normal business hours.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in your Benefits Summary.

You may seek Covered Services from any Network Primary Care Physician or from other Network Physicians without a Referral. Coverage for services in the office is at the primary care physician benefit level when you seek Covered Services directly from any Network Primary Care Physician. Coverage for services in the office is at the specialist benefit level when you seek Covered Services from any other Network Physician. You should validate the status of a Network Provider by calling Customer Service or accessing the on-line provider directory. Please refer to your Benefits Summary for details.

2.2 Out-of-Network Benefits

As described in your Benefits Summary, services provided by an Out-of-Network Provider are not covered unless otherwise stated in your Benefits Summary or unless prior authorization for coverage as an In-Network Benefit is received from us. Any amounts that QualChoice allows for Covered Services provided by an Out-of-Network Provider will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary for details:

1. **Certificate Provision:** The Benefits Summary or this Certificate specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Certificate, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Continuity of Care, Pregnancy, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage you were receiving obstetrical care from an Out-of-Network Provider for a pregnancy covered under the terms of this Certificate, that you were in the third trimester of your pregnancy on the effective date of your coverage, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits;
5. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If

QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;

6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Certificate, that you were in the third trimester of your pregnancy on the date that the Provider left the PPO, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing QualChoice, Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3 Network Provider Participation

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at an In-Network Benefit level. You may search the directory on our website at www.qualchoice.com or by calling our Customer Service Department at (800) 235-7111. Because contractual agreements can change, you should verify that a physician or provider is a Network Provider before you seek care.

We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if your Covered Services for that condition are approved by us prior to receiving the service.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A referral, whether written or oral, by a Network Provider to an Out-of-Network Provider; or
2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Provider to provide and coordinate all future Covered Services. If you do not make a change to a single Network Provider within 31 days of the date we notify you, we will assign a single Network Provider to you.

2.4 Cost Sharing Requirements

You must share in the cost of your Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult your Benefits Summary to determine the amounts of your payments under these Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill you for the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all charges. **These additional charges could amount to thousands of dollars in additional out-of-pocket expenses for which you are responsible.**

1. **Deductible:** The Deductible is a certain fixed dollar amount per Calendar Year, per person as set forth in your Benefits Summary.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time you receive a Covered Service to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket Limits for each Enrollee or family. Please see your Benefits Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of the Maximum Allowable Charge for the cost of Covered Services you must pay. Coinsurance payments are in addition to Deductibles or Co-payments. Your Benefits Summary contains your Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided to you.
4. **Limits on Your Out-of-Pocket Payments:** You will no longer have to pay Coinsurance for the remainder of the Calendar Year after you have met the Out-of-Pocket Limit during the Calendar Year. Your Benefits Summary lists your Out-of-Pocket Limit for Coinsurance. Coinsurance is the only amount that will apply towards your Out-of-Pocket Limit. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are your responsibility and do not count toward meeting the Out-of-Pocket Limit. Once your Out-of-Pocket Limit has been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge.

2.5 Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Certificate, and regardless of any other communications or materials you may receive in connection with your Certificate, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in . This standard applies to all sections of this Certificate.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Certificate. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.1.

2.6 Exclusion and Limitations

Some services are excluded from coverage and other services have specific coverage limitations.

This Certificate refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

Consult your Benefits Summary, Medical Policies, and Section 4.0 for information on benefit limitations and exclusions.

2.7 Enrollees Living Outside Service Area For More Than 90 Days

Enrollees that will live, work, or attend school outside the Service Area for more than 90 consecutive days should notify us. The Enrollee uses his/her QualChoice identification card to access Covered Services. Covered Services are processed at the In-Network Benefit level when provided by a QualChoice National Network (QCNN) healthcare provider. Covered Services for services not provided by a QualChoice National Network (QCNN) provider are will not be covered.

Enrollees who may use the QCNN for In-Network Benefits are:

1. Dependent students who are attending school outside the Service Area for at least 90 consecutive days, with renewal required annually; or
2. Dependent spouses and children who are living outside the Service Area for at least 90 consecutive days, with renewal required annually.

Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization for those services that we require to be pre-authorized (see Section 2.11) to receive Benefits at the In-Network Benefit level when accessing care from the QualChoice National Network (QCNN). It is the responsibility of the Enrollee to obtain the pre-authorization for Covered Services. QCNN providers are not responsible for obtaining a pre-authorization for services.

2.8 Coverage While Traveling Out of the Service Area

We cover the cost of Emergency health services an Enrollee incurs while traveling outside of the Service Area, but within the United States. An Enrollee is encouraged to seek services for Emergency health services from health care providers participating in the QualChoice National Network (QCNN) when the Enrollee is out of the Service Area. An Enrollee may limit out-of-pocket expenses for Emergency health services while outside of the Service Area to applicable Cost Sharing Amounts by accessing such care from a QCNN provider.

If care is accessed by an Enrollee from providers not participating in the QCNN, Covered Services received from such providers are not covered except in very limited circumstances as set forth in you Benefits Summary. We will deny coverage for routine and follow up care after Emergency health services unless a Network Provider in Arkansas performs the services.

The QualChoice identification card contains contact information for the QCNN. QCNN providers may be identified by calling the number on the identification card. The Enrollee must present their QualChoice identification card to the servicing provider indicating participation in the QCNN in order to receive this benefit. Submit a Claim for Benefits directly to us for processing. Provisions for Emergency health services as set forth in Section 3.10 must also be followed to receive maximum Benefits.

Dependents who have notified QualChoice that they reside outside the Service Area may access the QCNN providers and facilities for Covered Services at the In-Network benefit level upon prior approval by QualChoice.

2.9 General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of this Certificate. A final determination of eligibility is made at the time a Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a healthcare care provider, provided within the scope of that healthcare provider's license, and rendered in accordance with professionally recognized standards of care.

During the first year of this Certificate, the Benefits payable under this Certificate shall not exceed those that would have been payable had your Benefits under your former employer's group policy remained in force and effect.

2.10 Administration and Interpretation of this Certificate

We have sole and exclusive discretion to interpret the Benefits provided under this Certificate as well as all other provisions, terms, conditions, limitations and exclusions in the Certificate and to make factual determinations related to the Certificate and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Certificate. Subject to applicable law or regulation we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate the Certificate, in our sole discretion, without prior notice to or approval by Enrollees. Changes to this Certificate will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.11 Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services must be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

Your responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations for you. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QualChoice National Network (QCNN). QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not responsible for obtaining required pre-authorizations.

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if your clinical status has changed sufficiently that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service department. Any of our pre-authorization decisions may be appealed by following the procedures in Section 7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.12 Utilization Management

We cover Medically Necessary services as described in Section 2.5. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.13 Case Management

We provide a Case Management program. Case Management assists you to make the best use of your Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, high-risk pregnancy, transplants, oncology and neonatology.

2.14 QCARE

QCARE is our population health management program that facilitates access to medical services, and provides tools and self-management assistance to our Enrollees who have chronic medical conditions, such as diabetes, hypertension, and asthma. We work one-on-one with Enrollees to help them understand their illnesses better. We also educate Enrollees on treatment options so that the Enrollee can better manage their health.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this section subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11, and to all other applicable conditions, limitations and exclusions of this Certificate. **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.1 Advanced Diagnostic Imaging

Advanced diagnostic imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of your Certificate as set forth in your Benefits Summary; and
2. Pre-authorization is required for these tests. The requirements for pre-authorization are detailed in Section 2.11 must be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2 Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations as set forth in this Certificate. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in your Benefits Summary, and the following criteria:

1. When an accident or other medical Emergency occurs, we cover transport to the nearest facility when Emergency services are required;
2. We cover ambulance transportation from one facility to another facility for one of the reasons identified below as long as it is coordinated through the QualChoice Care Management department:
    A. To access equipment or expertise necessary to care for you properly;
    B. To receive a test or service which is not available at the facility where you have been admitted and you return after the test or service is completed;
    C. To transport you from an Out-of-Network Facility to a Network Facility; and
    D. To transport you directly from an acute care setting to an alternate level of care.

3.3 Complications of Pregnancy

Coverage is provided for treatment of Complications of Pregnancy when performed or prescribed by a physician subject to the Deductible and Coinsurance amounts specified in the Benefit Summary.

3.4 Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice prior to services being provided. Benefits are subject to a maximum limit per Enrollee per accident. See your Benefits Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery ("D.D.S.") or a Doctor of Medical Dentistry ("D.M.D."). The damage must be severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

The physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth; or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, or no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

If the Enrollee is under age 15, reimbursement for dental care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of QualChoice, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Enrollee is in force when the treatment is rendered.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position; reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5 Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility; and
2. The situation meets Medical Necessity criteria, and the patient is:
    A. A Child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible;
    B. A person with a serious mental health condition that prevents use of local anesthesia for the procedure;
    C. A person with a serious physical condition making facility care necessary for the safe performance of dental work; or
    D. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required (see Section 2.11). **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.6 Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis; and
7. Incision of accessory sinuses, salivary glands or ducts.

3.7 Dental – Other

Other dental care and orthodontic services are not covered.

3.8 Diabetes Management

Diabetes self-management training is limited to one program per lifetime per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9 Durable Medical Equipment

Durable Medical Equipment (DME) is equipment primarily and customarily serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used. DME is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person.

You must obtain all DME through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition of and description of coverage for orthotics and prosthetic devices and services are in Sections 3.22 and 3.27 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a Network DME Provider. It is your responsibility to confirm this with your physician. If DME dispensed by your physician is not from a Network DME Provider, you can obtain a prescription from your physician for the DME and contact us to assist in obtaining the equipment. Failure to insure all DME is obtained from a Network DME Provider will result in denial of Benefits.

3.10 Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section 11.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 11) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United States, are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling the number at the front of this Certificate.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If in an Emergency an Enrollee goes to an Out-of-Network Facility's emergency room for treatment and the Enrollee is admitted at that Out-of-Network Facility for further care or in-patient treatment, *the Enrollee, a family member or the Facility must notify our Care Management Department once the Enrollee is stabilized, but in no event more than forty-eight (48) hours after initial treatment*. Failure to notify us within the specified forty-eight (48) hour time requirement may result in a denial of Benefits. Upon receipt of such notification, we may either authorize the Enrollee's admission to, or further treatment at, the Out-of-Network Provider hospital, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Provider facility, the admitting physician, and the Enrollee's Network Provider. If the Enrollee stays at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the facility and other Out-of-Network Providers providing care to you.

3.11 Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

Benefits also include one routine vision exam, including refraction, to detect vision impairment by a Network Provider once every 24 months. Refraction is only covered when provided in conjunction with a routine vision examination.

Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery and for treatment of disease as specified in Section 4.1.

3.12 Family Planning Services
Coverage is provided for voluntary sterilizations (vasectomies and tubal ligations) except as excluded in Section 4.1

3.13 Home Health Services
Coverage is available for the following services provided in your home when your medical condition supports the need for such services, the services are ordered by a physician, and are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. (See your Benefits Summary for visit limitation details.)

The following services provided by a licensed home health agency in your home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled care, that is, skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse, is not Custodial Care;
2. Physical, occupational and speech therapy services;
3. Medical supplies provided by the home health agency during the course of approved care; and
4. Home services by a nurse midwife, except home deliveries.

3.14 Home Infusion Therapy
The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.
4. When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15 Hospice Services
Hospice services must be pre-authorized and arranged by a QualChoice Case Manager. Consult your Benefits Summary for applicable Cost Sharing Amounts. Coverage is available for Enrollees with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following hospice services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program, provided the hospice program was pre-authorized by QualChoice:

1. In-patient care in a freestanding hospice, a hospice unit within a facility or skilled nursing facility, or in an acute care facility bed; and
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including, but not limited to, the following:
    A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
    B. Respiratory therapy;
    C. Social services;
    D. Nutritional services;
    E. Laboratory examinations;

F. Chemotherapy and radiation therapy when required for control of symptoms;
G. Medical supplies; and
H. Medical care provided by a physician.

3.16 Facility – In-patient Care

In-patient facility care Benefits are available for services and supplies received during the facility stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any facility services unless the service is provided to the Enrollee by an employee of the facility, the facility bills for the service, the service is not primarily for convenience, and the facility retains the payment collected for the service.

Hospital in-patient care is also subject to the following conditions:

1. We cover Medically Necessary acute in-patient facility care for the care or treatment of the Enrollee's condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance.
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy.
4. We do not provide Benefits while an Enrollee is waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
   A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
   B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
   C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred;
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment.

   .
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.11. Please call the number listed on your identification card to notify us of the admission.

3.17 Injectible Prescription Medications

Benefits are available for Injectible Prescription Medication(s) received only when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility based upon the Maximum Allowable Charge for the Injectible Prescription Medication and subject to the applicable Cost Sharing Amounts specified in your Benefits Summary.

3.18 Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19 Maternity Services

The following maternity services are covered ***only*** if you or your enrolled spouse is pregnant as of the effective date of this Certificate:

1. **Fetal Testing:** Amniocentesis or chorionic villus sampling is covered when performed in accordance with recognized standards of care.

2. **In-patient Hospital Stays; Statement of Rights Under the Newborns' and Mothers' Health Protection Act.** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any facility length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

   We will pay for an in-patient facility stay of at least 48 hours for the mother and newborn Child following a normal vaginal delivery. We will pay for an in-patient facility stay of at least 96 hours for the mother and newborn Child following a cesarean section delivery. However, we may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
   Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

   In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact our Customer Service department.
3. **Maternity and Obstetrical Care:** Coverage is provided for Maternity and Obstetrical Care, including routine prenatal care, postnatal care, delivery in an in-patient facility setting, and any related complications. Routine prenatal care includes coverage of only one routine ultrasound usually done between the 16th and 22nd week of pregnancy. If additional ultrasounds are needed due to Medical Necessity, pre-authorization is required. QualChoice provides special prenatal programs designed to benefit you and your baby during pregnancy. These are available at no additional cost and are voluntary. To sign up, you should contact us as early as possible during your pregnancy.
4. **Midwives:** Coverage is provided for services received from a certified nurse midwife, but only if that nurse midwife is a Network Provider and the delivery is done in an in-patient facility setting.
5. **Newborn Care in the Hospital:** A newborn Child of the Certificate Holder or the Certificate Holder's spouse will be covered from the date of birth, including use of newborn nursery and related services, provided the Child's coverage becomes effective on his or her date of birth subject to the requirements of Section 5.0 being met.

3.20 Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a Network Physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds $2,400 per year per person.

The covered amount will be the incurred cost of medical food or low protein modified food products that are in excess of the $2,400 per year per person, subject to the Cost Sharing Amounts specified in your Benefits Summary.

3.21 Medical Supplies

Medical supplies are items that are consumed or reduced with use so that they cannot be repeatedly used, are primarily or customarily used for medical purposes, and are generally not useful in the

absence of an illness or injury. Medical supplies do not include medications or implants. Medical supplies are only covered when prescribed by a physician and when Medically Necessary.

The following conditions will also apply to coverage for Medical supplies:

1. Coverage for medical supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for medical supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used; and
3. Coverage for medical supplies is limited to a 31-day supply per month.

3.22 Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does ***not*** include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.23 Outpatient Services

Outpatient Covered Services are as follows:

1. Outpatient Facility Services: Subject to all of the terms, conditions, limitations and exclusions of this Certificate, Covered Services shall include services provided in a licensed outpatient facility or at a facility outpatient department. Examples include diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for in-patient admission.

2. Outpatient Surgery: Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient facility setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service.

We cover Medically Necessary surgical services. We apply multiple surgical procedures reduction when the same provider performs two or more surgical procedures on the same Enrollee within the same operative session.

3.24 Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefits Summary.

3.25 Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com or you may contact our Customer Service department to obtain specific coverage guidelines.

3.26 Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Certificate and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).
2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;

5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.27 Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.28 Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Certificate.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Enrollee;
2. Surgery performed on a child for the correction of a cleft palate or cleft lip, removal of a port-wine stain (**only** on the face), or correction of a congenital abnormality. In order to be covered, such corrective surgery for a congenital defect must be performed when the child is twelve (12) years or younger, unless, in its sole discretion QualChoice determines that due to the complexity of the procedure, such surgery could not be performed prior to the child's twelfth (12^{th}) birthday. Dental care to correct congenital defects is not a covered benefit;
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery;
4. In connection with a mastectomy eligible for coverage under this Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphademas; or
5. Reduction Mammoplasty that meets our criteria for coverage (which you may request to obtain a copy from us) is a Covered Service subject to Deductible and 50% Coinsurance. Pre-authorization is required.

Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. As further explained in Section 4.1, we do not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services.

3.29 Skilled Nursing Facility and In-patient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute in-patient rehabilitation facility when provided immediately after hospitalization in an acute care general facility for a covered illness or injury. Care will be limited to the number of covered days provided by your Certificate and if Medically Necessary for continued improvement. See your Benefits Summary for details.

3.30 Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a facility. Refer to your Benefits Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.31 Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Certificate. Consult your Benefits Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your QualChoice identification card to obtain pre-authorization before your evaluation for transplant and placement on any transplant list***. Once the evaluation is complete, you must obtain an additional pre-authorization for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the Certificate as follows:

A. **Transplant Covered Services:** We will cover any facility, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us**.
B. **Facility Care:** We cover all in-patient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network Facility, we may require Network Providers at a Network Facility to provide some follow-up care.
C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. This coverage applies to the donor whose organ has been selected to be used in the transplantation. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health plan indicating coverage or denial for the donation.) Please refer to your Benefits Summary for Cost Sharing Amounts and lifetime maximums.

3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   A. Aplastic anemia
   B. Wiscott-Aldrich syndrome
   C. Albers-Schonberg syndrome
   D. Hemoglobinopathy, e.g., Thalassemia major
   E. Myelodysplastic syndromes – primary and acquired
   F. Immunodeficiency syndrome
   G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   I. Neuroblastoma, stage III or IV
   J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   K. Chronic myelogenous leukemia in the chronic phase
   L. Multiple myeloma
   M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse
   N. Chronic Lymphocytic Leukemia
   O. Marrow failure, Fanconi's, red cell aplasia
   P. Amyloidoosis
   Q. Paroxysmal Nocturnal Hemoglobinuria

   This Certificate requires specific donor matches for certain procedures.

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Certificate. Cornea transplantation does not require pre-authorization.

IMPORTANT NOTE REGARDING TRANSPLANTATION SERVICES: It is important that you review and understand the benefit limitations for transplant services described in Section 4.2 of this Certificate.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This section describes those exclusions and limitations. One or more of our optional coverage riders may cover some of these items. If you have purchased riders, they will be provided to you in writing. Please refer to your Benefits Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded

or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1 Non-Covered Services and Exclusions from Coverage

1. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.
2. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted Child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges. For the purpose of this Certificate, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth. Refer to Section 5.1 for information regarding coverage of adopted children.
3. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
4. **Against Medical Advice:** We will not cover any services related to an in-patient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
5. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as the following:
   A. Acupuncture;
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy;
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy; and
   K. Massage Therapy (except as provided for in QualChoice's Medical Policies).
6. **Baby Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
7. **Blood and Blood Donation:** We do not pay for any charges associated with blood donations. We do not pay for procurement, or storage, of donated blood. We do not cover umbilical cord blood banking or blood banking for blood or blood products with unscheduled future use. We do cover the charges for administration of blood and blood products. We do cover blood or blood product banking charges for covered procedures planned in the next 180 days.
8. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
9. **Care Plan Oversight**: Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
10. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
11. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in facilities not licensed as short-term acute care general facility or skilled nursing facilities, for example:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;

D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis facility;
E. Infirmaries at camps or schools;
F. Hospitals for treatment of a Mental Health or Substance Use Disorder;
G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);
H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.29);
I. Extended care, chronic care, or transitional facilities or facilities (except as covered under Section 3.29); or
J. Other facilities and institutions, which do not meet our criteria for short-term acute care general facility or skilled nursing facilities

12. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
13. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year annual treatment limits or lifetime maximums as shown on the Benefits Summary.
14. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
15. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
16. **Chemical Ecology:** Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
17. **Chiropractic Care:** Chiropractic care services are not covered.
18. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
19. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the-counter (without a prescription) are not covered.
20. **Convenience Items or Services:** We will not cover items or services utilized primarily for your convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to, a cot, hot water bottle, telephone, television, television rental charges, whirlpool bath, automobile/van conversion, wheel chair ramp, and home modifications.
21. **Cosmetic or Reconstructive Services**: Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. We will not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services. Procedures or services that change or improve appearance without improving physiological function are also not covered. Procedures or services that correct a physical developmental defect present at the time of birth without improving or restoring physiologic function are considered cosmetic procedures. The fact that an Enrollee may suffer psychological consequences as a result of an injury, sickness or developmental defect present at the time of birth, does not make the service Medically Necessary.
22. **Custodial Care:** We do not cover Custodial Care. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial Care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding, or range of motion exercises. Non-covered Custodial Care may be rendered in a facility, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.

23. **Dental Care:** This Certificate does not provide Benefits for dental care. Except as otherwise stated in this Certificate, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess;
    G. Treatment of dentigerous cysts;
    H. Removal of soft tissue supporting or surrounding teeth;
    I. Orthodontia (including braces);
    J. False teeth;
    K. Orthognathic surgery; or
    L. Any other dental services you may receive, except as specifically set out in your Benefits Summary.
24. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.
25. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.
26. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit, and motor dysfunctions are not covered. Except for an autism screening occurring one time between the ages of 1 and 4, this includes an exclusion for developmental delay associated with autism spectrum disorder.
27. **Dietary and Nutritional Services:** Unless dietary supplies are the sole source of nutrition for the Enrollee (see Section 3.21 - Medical Foods), any services or supplies provided for dietary or nutritional services, including, but not limited to, medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a physician or acquired over-the-counter, are not a covered.
28. **Domestic Partners:** We do not provide coverage for domestic partners of the same sex or opposite sex.
29. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.
30. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
31. **Electronic Consultations:** We do not cover charges for a healthcare provider's consultation by telephone, email, or other electronic communications with you or another healthcare provider.
32. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, are not covered. However, subject to all terms, conditions, exclusion and limitations as set forth in this Certificate; coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.
33. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is not covered. However, subject to all terms, conditions, exclusion and limitations in this Certificate, and at the sole determination of QualChoice, coverage may be provided for enhanced external counterpulsation for the treatment of Enrollees with coronary artery disease documented by coronary artery catheterization. Our Medical Policy regarding enhanced external counterpulsation is available on our website www.qualchoice.com or you may contact our customer service department to obtain specific coverage guidelines.
34. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.
35. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under this Certificate, on grounds of excessive use when it is the determination

of our medical director that: (1) an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia, or by the QualChoice Pharmacy & Therapeutics Committee; or (2) an Enrollee has obtained or attempted to obtain the same medication from more than one physician for the same or overlapping periods of time; or (3) the pattern of prescription medication purchases, changes of physicians or pharmacy, or other information indicates an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider, or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use, or activity to evaluate for excessive use.

36. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a physician.
37. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.
38. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including, but not limited to, plantar fasciitis or tennis elbow, is not covered.
39. **First Aid Supplies:** We will not cover over-the-counter first aid supplies.
40. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, non-surgical care of bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations of this Certificate, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
41. **Foot Orthotics:** Foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.
42. **Fraud or Misrepresentation:** Health interventions or health services, including, but not limited to, medications obtained by unauthorized or fraudulent use of an Enrollee's QualChoice identification card or by material misrepresentation as part of your enrollment process or at other times, are not covered.
43. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you and/or the provider did not think there would be insurance when the provider chose not to charge for the care provided.
44. **Government Programs:** We will not pay for Covered Services to the extent Benefits for such services are payable under Medicare or any other federal, state or local government program.
45. **Group Therapy:** Group therapy or group counseling at any time in any setting by any provider is not covered.
46. **Hair Loss or Growth:** Wigs, hair transplants, or any medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a physician, are not covered

regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.

47. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered. Cochlear implants are the only exception to this exclusion as specified in Section 4.2(4).
48. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.
49. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants, and Nonmyeloalative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.31.
50. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
51. **Illegal Acts:** Except as required by law, we will not cover health care services resulting from participation in a felony, riot, insurrection, or other illegal act, whether or not convicted.
52. **Illegal Uses:** Medications, drugs, or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or accidental injuries from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits are not covered.
53. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury, or prostate surgery.
54. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered.
55. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications, procedures, or other services for treatment of infertility. It does not matter whether the infertility service is diagnostic or therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:
    A. Reversal of sterilization;
    B. Pre-implantation testing;
    C. Surrogate pregnancies;
    D. Medical treatment of infertility;
    E. Surgical treatment of infertility; and
    F. In vitro fertilization

    Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying cause of the infertility are detected or treated during such surgery.
56. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, where the Enrollee is on a cardiac transplant list at a facility where there is an ongoing cardiac transplantation program, the Certificate will cover infusion of inotropic agents.
57. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars, or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.
58. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.

59. **Learning Disabilities:** Services or supplies provided for learning disabilities, for example, reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties, are not covered.
60. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. is not covered.
61. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
62. **Maintenance Therapy:** We will not cover maintenance therapy for physical therapy, occupational therapy, or speech therapy.
63. **Mammoplasty:** Except as provided in Section 3.28, we do not cover mammoplasty for reasons of augmentation or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.
64. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party such as, but not limited to, an employer, licensing board, recreation council, or school.
65. **Marriage and Relationship Counseling:** Marriage and relationship counseling services are not covered.
66. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms or the preparation or copying of medical records.
67. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services, or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications, counseling, weight maintenance programs, gastric stapling, gastric bypass, or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.
68. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including, but not limited to, a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.
69. **Mental Health or Substance Use Disorder:** Services of any kind or nature for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse are not covered. Services that are excluded include, but are not limited to:
    A. Testing, evaluation, assessment and/or treatment of every diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
    B. Hypnotherapy;
    C. Treatment of behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
    D. Hospitalization for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse;
    E. Evaluation of psychosocial factors potentially impacting physical health problems and treatments, including health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems;
    F. Services for treatment of eating disorders are not covered; this exclusion includes treatment for anorexia, bulimia and other eating disorders; and
    G. Family counseling in conjunction with an Enrollee's individual crisis therapy.
70. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of an Enrollee's refusal to comply with a physician's or other provider's

recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.

71. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.
72. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.
73. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.
74. **Over-the-Counter Medications:** Medications (except insulin) which do not by law require a prescription from a physician are not covered.
75. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
76. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
77. **Percutaneous diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.
78. **Percutaneous Kyphoplasty:** Percutaneous kyphoplasty is not covered.
79. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
80. **Performance Enhancement:** We will not cover medical, surgical, or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic, or recreational performance, including, but not limited to, work hardening programs, back schools, programs of general physical conditioning, athletic trainers, and special or specially modified surgical procedures designed to enhance performance above normal.
81. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.
82. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
83. **Pre-existing Conditions:** Benefits for the treatment of a Pre-existing Condition are excluded until you have had continuous coverage under your previous group policy and this Certificate combined for 12 months. This exclusion does not apply to coverage for maternity services for a pregnancy in existence as of the effective date of this Certificate or to an Enrollee under the age of 19.
84. **Pre-Implantation Genetic Diagnosis:** We do not cover pre-implantation genetic diagnosis or treatment.
85. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.
86. **Prescription Drugs:** We do not cover medications prescribed for an Enrollee for use on an outpatient basis, that is, medications not dispensed or administered when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility.
87. **Private Duty Nurses:** We will not cover private duty nurses.
88. **Private Room:** We do not cover a private facility room. We will pay the most common charge for semi-private accommodations. If you are charged for a private room, you must pay the difference between the charges for a private room and our payment.
89. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
90. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
91. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:
    A. Obtaining employment;
    B. Maintaining employment;
    C. Obtaining insurance;
    D. Obtaining professional or other licenses;
    E. Engaging in travel;

F. Athletic or recreational activities; or
G. Attending a school, camp, or other program.

92. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
93. **Rest Cures:** Services or supplies for rest cures are not covered.
94. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
95. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.
96. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental) meeting the definition of a Mental Health or Substance Abuse Disorder.
97. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
98. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Certificate as being a Covered Service.
99. **Services Received Outside the United States:** Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of QualChoice.
100. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
101. **Sexual and Gender Identity Disorders**: Any services related to the treatment of sexual and gender identity disorders are not covered.
102. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome are not covered, except when short stature is caused by laboratory documented growth hormone deficiency.
103. **Sleep Apnea, Portable Studies:** Studies for the diagnosis, assessment, or management of obstructive sleep apnea, not continuously attended by a qualified technician, are not covered.
104. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is included with this Certificate, treatment of caffeine, smoking, or nicotine addiction, smoking cessation prescription medication products, including, but not limited to, nicotine gum and nicotine patches, are not covered.
105. **Snoring:** Devices, procedures, or supplies to treat snoring are not covered.
106. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.
107. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.
108. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Certificate, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical, and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including, but not limited to, the shortening of the mandible or maxillae or the correction of malocclusion.
109. **Thermography:** Thermography, which is the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
110. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or facility or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Certificate prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money

received by the Enrollee from the third party, or its insurer. Please refer to Section 8 and Section 10.8 for further information concerning repayment of Benefits.

111. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
112. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
113. **Trans-telephonic Home Spirometry:** Trans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
114. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for ground or air emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department. Refer to your Benefits Summary for limitations.
115. **Travel, School, Recreation, or Work Related Immunizations:** Except to the extent coverage is specifically provided in this Certificate as a preventive health benefit, we will not cover immunizations to fulfill requirements for international travel, school, recreation, or for work.
116. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.
117. **Vision:** Except as set forth in the Benefits Summary, we will not cover routine eye, services or tests, eyeglasses, contact lenses, and other vision care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes.
118. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglass and contact lenses (except the initial acquisition of one pair within the twelve months following cataract surgery up to $200 for frames and lenses), are not covered.
119. **Vitamins or Supplements:** Vitamins or nutrient supplements not available over the counter are not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism as described in Section 3.21 – Medical Foods.
120. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.
121. **Weight Control:** Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
122. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
123. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition, or disease arising from your employment. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law.
124. **Wound Treatment:** Blood derived growth factors are not covered.

4.2 Limitations to Benefits

Coverage is available for medical services or care as specified in this Section 4.2 subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11, and to all other applicable conditions, limitations and exclusions of this Certificate.

1. **Ambulance:** Transportation by ambulance of any kind is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult your Benefits Summary for benefit limitations.
2. **Auditory Brain Stem Implant.** One auditory brain stem implant per lifetime is covered for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone removal of bilateral acoustic tumors.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Cochlear Implants:** Coverage for cochlear implants is subject to a maximum lifetime benefit of $20,000 per Enrollee. Coverage is limited to one cochlear implant device, the surgical procedure, and one speech processor. Reimplantation of the same device is not covered. Pre-authorization is required.
5. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of facility or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
6. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Out-of Network DME is not covered. Please refer to your Benefits Summary for this annual limit.
7. **Genetic Counseling and Testing:** Genetic testing is generally not covered. Genetic testing is often done on blood or tissue samples sent by your physician to a laboratory. *For genetic counseling or testing to be covered, it requires pre-authorization.* Pre-authorization will only be given in accordance with QualChoice's Medical Policies which require the results of the genetic testing to affect choice of treatment or the outcome of treatment. We will not cover genetic counseling or testing to determine the likelihood of:
    A. Developing a disease or condition; or
    B. Disease or the presence of a disease in a relative; or
    C. Passing an inheritable disease, for example, cystic fibrosis, or congenital abnormality to an offspring.

    However, subject to all terms, conditions, exclusions and limitations set out in this Certificate, genetic testing of the products of an amniocentesis to determine the presence of a disease or congenital anomaly in the fetus or genetic testing of an Enrollee's tissue to determine if the Enrollee has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered if the test meets QualChoice's Medical Necessity criteria. Any approved genetic testing must be preceded by genetic counseling.
8. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Contract Year. The home health care visit limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
9. **Hospice Services:** Hospice services are limited to a maximum number of days of coverage per Enrollee. The hospice services day limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
10. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
11. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.

12. **Lifetime Maximum:** Consult your Benefits Summary and this Certificate for various lifetime maximum Benefits per Enrollee.
13. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Physicians and Network Facilities will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
14. **Medical Supplies:** Coverage of medical supplies is limited to a 31-day supply per month.
15. **Newborn Care:** We will cover Newborn Children of the Certificate Holder or spouse from the date of birth provided the Certificate Holder enrolls the newborn within 90 days after the date of birth.
16. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation, and cardiac rehabilitation services are limited to a maximum number of visits per Enrollee per Contract Year as reflected in your Benefits Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider will not be covered as set out in your Benefits Summary.
17. **Prosthetic and Orthotic Devices and Services.** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.
18. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Physicians for personal reasons. In such case, neither we nor any Network Physician or Provider shall have any further responsibility to provide care for the condition under treatment, unless you later recant the refusal and agree to follow the recommended treatment or procedure.
19. **Shoes and Shoe Inserts:** Custom molded and fitted shoes and shoe inserts are not covered except for an Enrollee with diabetes. Coverage for an Enrollee with diabetes for custom molded and fitted shoes and shoe inserts is subject to the following limitations:
    A. Two (2) pairs of custom molded and fitted shoes per year if the Enrollee is under 18 years of age and one (1) pair of custom molded and fitted shoes for an Enrollee 18 years of age or older; and
    B. Two (2) pairs of custom molded shoe inserts per year.
20. **Transplant Services:** Transplant services are subject to the following benefit maximums and limitations:
    A. Coverage for procurement and testing (per transplant) is limited to the amount reflected in your Benefits Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary ;
    C. We will not cover the transportation and/or lodging costs of the transplant recipient, transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs;
    D. Coverage is limited to no more than the number of transplants per Enrollee per lifetime as reflected in your Benefits Summary. We cover re-transplantation, but a re-transplant is considered a transplant and counts toward the transplant limit;
    E. Expenses for drugs related to avoidance of rejection of a transplanted organ are subject to the lifetime transplant maximum as reflected in your Benefits Summary;
    F. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission, or in complete remission less than two (2) years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small

or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis; and

G. **Transplants that are not pre-authorized by QualChoice Care Management Department are not covered.**

5. ELIGIBILITY CRITERIA

5.1 Who is Eligible for Coverage

Only you and your dependents who were covered under your original employer group policy on the date of termination of coverage under that employer group policy are eligible for coverage under this Certificate. You must list yourself and any of your eligible dependents you are electing to cover on the Enrollment Application to be eligible for coverage. If you do not list them on the Enrollment Application, they will not be eligible for coverage under this Certificate. You and your dependents must meet all eligibility requirements in this Certificate. The following members of your family may be eligible as dependents as long as they were covered under your original employer group policy on the date of termination of coverage under that employer group policy:

1. Your spouse, unless you are divorced or have annulled your marriage. Domestic partners are not eligible for coverage as a dependent under this Certificate.
2. Your Child until s/he becomes twenty-six (26) years of age. However, if your prior employer group policy is a grandfathered plan, your Child nineteen (19) years of age and older but who has not attained the age of twenty-six (26) years is eligible only if s/he is not otherwise eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.
3. Your incapacitated Child may be an eligible dependent. The incapacitated Child must be twenty-six (26) years of age or older and totally disabled due to continuous developmental or physical incapacity. The incapacitated Child must be primarily dependent on you for financial support and you must declare the incapacitated Child as a dependent on your federal income tax returns. The disability leading to mental or physical incapacity must have occurred before the Child reached age twenty-six (26) and while covered under this Certificate or other group medical insurance coverage. The Social Security Administration or a physician must medically certify the disability. In addition to this medical certification, we have the unilateral right to determine whether a Child is, and continues to qualify as an incapacitated Child. At any time, we may request a declaration of disability (or like document) supporting such dependent's incapacity and dependency. You must notify us if the incapacity or dependency is removed or terminated. Newly eligible Enrollees may enroll an incapacitated Child provided the disability commenced before the limiting age and a health benefit plan continuously covered the Child as your dependent since before the limiting age. Our determination of eligibility shall be conclusive.
4. Coverage for a Child whom you have adopted or for whom you have filed a petition for adoption shall begin on the date of the adoption or the date of the filing of the petition for adoption. You must submit an Enrollment Application to us within 60 days after the adoption or the filing of the petition. Coverage will begin subject to payment of all applicable premiums. The coverage shall begin from the moment of birth if the petition for adoption or adoption occurred and you submit the application for coverage to us within 60 days of the birth of the Child. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

Your coverage begins upon the effective date of this Certificate which is the day following your termination of your coverage under the group Certificate. You should contact our Customer Service Department for information concerning your eligibility requirements and effective date. You will not be eligible to enroll if you do not meet the eligibility rules of this Certificate.

Neither you nor your dependent will be eligible to enroll if:

1. You have had previous coverage with us terminated for causes described in Section 5.4(5) of this Certificate.
2. Such person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program.
3. Such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.
4. Such benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.
5. The benefits provided under subparagraph (2) above for such person, or benefits provided or available under the sources referred to in subparagraphs (3) and (4) above for such person, together with the benefits provided by this Certificate, would result in over-insurance according to our standards as filed with Arkansas Insurance Department, if any.
6. If such person is eligible for Medicare.

Coverage for newborn or adopted children in your family begins on the date they meet the eligibility requirements of this Certificate. Coverage for your newborn Child is effective as of the date of birth if you submit an Enrollment Application to us within 90 days of the date of birth of the Child or before the next premium due date, whichever is later. Coverage for your adopted Child is effective as of the date of the adoption if you submit an Enrollment Application to us within 90 days of the date of the adoption of the Child or before the next premium due date, whichever is later.

Coverage, subject to all other terms, conditions, exclusions and limitations of this Certificate, will be extended to an eligible Enrollee who is inpatient in a facility on the effective date of this Certificate. However, consistent with applicable law, if such eligible Enrollee is inpatient in a facility on the effective date of this Certificate and immediately prior to such effective date was covered by a group health plan that provides coverage for facility or medical services or expenses, coverage for benefits under that other group health plan will continue and it will be primarily responsible for those services and expenses associated with that facility admission. As the primary plan, that other group health plan will be responsible for those services and expenses until the end of that facility admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

If your Covered Dependent gives birth, the newborn grandchild is not eligible for coverage. If you, as the Child's grandparent, adopt or become the legal guardian of the Child, we will cover the Child from the effective date of the adoption or the legal guardianship.

5.2 Termination of Coverage

Your coverage under this Certificate will terminate in certain circumstances. We describe these circumstances below.

1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Certificate. Failure to remit premium payments to us in accordance with these terms may result in the suspension of Benefits for you and your Covered Dependents. In the event you do not respond timely to written and verbal demands for payment by us, coverage under this Certificate will be terminated retroactive to the last day of the month for which premium payment was received.
2. **Certificate Holder's Death:** Coverage for Covered Dependents under this Certificate will automatically terminate on the date of the Certificate Holder's death.
3. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.
4. **Termination of Your Marriage:** If you divorce, legally separate, or annul your marriage, the coverage of the Certificate Holder's spouse will automatically **terminate on the date of the** divorce, legal separation, or annulment. A court order requiring the Certificate Holder to provide coverage for the former spouse does not change the termination of coverage.

5. **Termination of Coverage of A Dependent Child:** The coverage of a Child under this Certificate will terminate automatically on the earliest of the following dates on which the Child:
    A. No longer meets the limiting age eligibility requirements;
    B. For a Child incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support; termination of coverage based upon age limitation(s) does not apply to a Child who qualifies as an incapacitated Child.
6. **Our Option to Terminate This Certificate:** We may terminate this Certificate for any of the following reasons:
    A. An Enrollee's intentional misrepresentation of material fact or fraud committed by the Enrollee in connection with any Claim for Benefits filed under this Certificate;
    B. Upon 30 days advance written notice to an Enrollee if he or she persistently fails to cooperate in good faith with the administration of coverage under this Certificate or persistently refuses to comply with treatment plans prescribed by a physician and approved by us;
    C. An Enrollee's coverage for failure to pay any applicable Cost Sharing Amount required under this Certificate upon 30 days advance written notice to such Enrollee unless default in payment is cured within such 30-day period;
    D. Upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's QualChoice identification card or if the Enrollee otherwise cooperates in the unauthorized use of the Enrollee's identification card or Benefits;
    E. Each Enrollee represents all statements made in his or her application for membership, and any applications for membership of dependents, are true to the best of his or her knowledge and belief. If an Enrollee performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, we may void his or her enrollment under this Certificate and the enrollment of his or her covered spouse and dependents. No statement made, for obtaining coverage, will void coverage unless the statement is written in the application and you, the Certificate Holder, signs it;
    F. Failure of an Enrollee to provide information necessary for QualChoice to comply with applicable law, including, but not limited to, the Enrollee's social security number or other government issued identification number;
    G. An Enrollee becomes eligible to enroll in a group health plan or government run health plan and all pre-existing conditions are covered under such group health plan or government run health plan; or
    H. Failure to respond to a request for Recovery of Overpayment in accordance with the provisions of Section 10.8.

    QualChoice will notify the affected Enrollee of a decision to terminate the Enrollee's coverage pursuant to the requirements of applicable law. If QualChoice terminates the coverage of an Enrollee, QualChoice shall have no further liability under this Certificate.
7. **Enrollees on Military Leave:** Enrollees (or an Enrollee's Covered Dependent) called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights apply to covered Enrollees and their Covered Dependents immediately before leaving for military service. The following applies to this election:
    A. The maximum period of coverage of a person under such an election shall be the lesser of:
        1. The 24 month period beginning on the date on which the person's absence begins; or
        2. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
    B. A person who elects to continue health plan coverage must pay up to 102% of the full contribution, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

C. An exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed services.

8. **Hospital Confinement at Time of Termination**: If an Enrollee is facility confined on the date coverage under this Certificate terminates, coverage for such hospitalization will be determined according to the following criteria:
   A. If the Enrollee replaces this Certificate with other coverage, coverage for the Enrollee will continue until facility discharge or Benefits under this Certificate are exhausted, whichever occurs first;
   B. If the Enrollee **does not** replace this Certificate with other coverage, coverage for the Enrollee will cease on the effective date of termination; or
   C. If termination is a result of rescission of coverage by QualChoice, coverage ends on the effective date of such rescission.

   If the hospitalized Enrollee is the Certificate Holder, coverage for any Covered Dependents of this Enrollee ends on the effective date of termination.

6. COORDINATION OF BENEFITS

You and your family members may have coverage under more than one health plan. This Certificate contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1 How COB Works

The order of benefit determination rules govern the order in which each health plan will pay a claim for benefits. The health plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another health plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all health plans do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2 Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary plan coverage:

1. If a health plan does not have a COB provision, that plan is primary.
2. The health plan covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health plan that covers the person as a dependent is secondary.
3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health plan the order of benefits is determined as follows:

   A. For a child whose parents are married or are living together, whether or not they have ever been married:

      (1) The health plan of the parent whose birthday falls earlier in the calendar year is primary; or

      (2) If both parents have the same birthday, the health plan that has covered the parent the longest is primary.

   B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

      (1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);

(2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) Plan of the custodial parent;

(b) Plan of the custodial parent's new spouse (if remarried);

(c) Plan of the non-custodial parent; and then

(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health plan of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The health plan covering that same person as a retired or laid-off employee is secondary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health plan, the health plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health plan does not have this rule, and as a result, the health plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

6. The health plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health plan that covered the person the shorter period of time is secondary.

7. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health plans. In addition, this Certificate will not pay more than it would have paid had it been primary.

6.3 Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan covering the Enrollee. This means an expense or service not covered by any plan covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans cover you and compute their benefit payments based on that plan's maximum allowable payment, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans and the Allowable Expense is determined by more than one method, the primary plan's payment arrangement shall be the Allowable Expense for all plans.

6.4 Reduction of Benefits

When this Certificate is secondary, we will reduce our benefits so that the total benefits paid or provided by all plans are not more than one hundred percent (100%) of the total Allowable Expense of the primary plan.

A. In determining the amount to be paid for any claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary plan. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total Benefits paid or provided by all health plans for the claim do not exceed the total Allowable Expense of the primary plan for that claim.
B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.
C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5 Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Certificate and other health plans. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Certificate and other health plans covering the person claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under this Certificate. If it does, QualChoice may pay that amount to the other plan that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7 Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8 Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by a group health plan that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary plan for those services and expenses associated with that hospital admission. As the primary plan, that group health plan will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

7. Complaints and Appeals

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of Certificate language, and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and

binding on the Enrollee and this Certificate. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

7.1 Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Certificate. Our Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request a Level I Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 9.3 below. An "appeal" must be initiated and conducted as described in Section 9.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Department at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:
   QualChoice
   Attention: Appeals and Grievance Coordinator
   P. O. Box 25610
   Little Rock, Arkansas 72221-5610
4. **Complaint Resolution:** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

7.2 Types of Requests and Claims

1. **Pre-Service Claim:** A Pre-Service Claim is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Certificate.
2. **Post-Service Claims:** Post-Service Claims are those claims for services that have already been received by the Enrollee.
3. **Urgent Care Claim:** An Urgent Care Claim is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:
   A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or
   B. Life, health or ability to regain maximum function could be seriously jeopardized.
4. **Concurrent Care Claim**: A Concurrent Care Claim is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.
6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

7.3 Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Level I Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Claim, Concurrent Care Claim or Urgent Care Claim) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 9. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator
   P.O. Box 25610
   Little Rock, AR 72221-5610

2. **Appeal of Pre-Service Claim and Concurrent Care Claim**
   A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee, and respond as soon as possible, but not later than fifteen (15) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
   B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
   C. **Initiating a Pre-Service or Concurrent Care Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing to our Complaint and Appeals Coordinator at the address listed in Subparagraph 1 above.
   D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider have the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within fifteen (15) calendar days of the Committee's hearing.
   E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within fifteen (15) calendar days from the receipt of the appeal.
   F. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Claim or Concurrent Care Claim will be treated as an appeal of an Urgent Care Claim as described in Section 9.3 below subject to the request meeting the criteria for an Urgent Care Claim.

3. **Appeal of Post-Service Claims**
   A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer, will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee and respond with a decision as soon as possible, but not later than thirty (30) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the

decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.

C. **Initiating a Post Service Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing or facsimile to our Complaint and Appeals Coordinator at the address or fax number listed in Subparagraph 1 above.

D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within thirty (30) calendar days of the Committee's hearing.

E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within thirty (30) calendar days from the receipt of the appeal.

F. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Claim**

A. **Initiating a Level I Appeal and Level II Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413. An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.

B. **Level I Appeal and Level II Appeal.** An appeal of an Urgent Care Claim will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review. A medical director different than the one that made the Level I Appeal decision will make the Level II Appeal decision.

7.4 Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Claim as defined in Section 9.2 above can initially be submitted orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Claim appeal even though investigation will have begun.
2. **Right to Information of Enrollee:** We shall provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:

A. Were relied upon in making the benefit determination;

B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
C. Demonstrate compliance with the terms of the Certificate; and
D. Constitute a statement of policy or guidance with respect to the Certificate concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Claim or Concurrent Care Claim, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the appeal do not accompany the appeal of a Medical Issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

7.5 Conduct of Appeals

An appeal is conducted following the procedures below:

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.
2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by QualChoice with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

7.6 Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

7.7 Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.
2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.
3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:
    A. An individual designated by the Enrollee in writing in a form approved by us;
    B. The treating provider, if it is a Pre-Service Claim, a Concurrent Care Claim, or an Urgent Care Claim, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
    C. A person holding the Enrollee's durable power of attorney;
    D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
    E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.
4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.
5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

    If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Claim or Concurrent Care Claim, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

7.8 External Medical Review

After you have exhausted your Level I and Level II appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Claim, please contact QualChoice's Appeal Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in the Certificate, an express limitation in the Certificate, dollar limits under the Certificate, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on both you and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this section. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 10 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if you have an injury or illness caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for your Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If you receive payment from a third party or any other insurer for the cost of Covered Services, you are obligated to reimburse us. You may reduce such reimbursement by our pro rata share of reasonable attorney's fees and costs you incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 10. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance as we may reasonably require to fully enforcing the terms of this Section 10. You agree to take no action prejudicing our rights and interests under this Section 10.

9. PRE-EXISTING CONDITIONS

Except as otherwise provided in Subparagraph 9.2 below, no Benefits for services of any kind are provided under this Certificate for treatment of an Enrollee's Pre-existing Condition (as defined in the

Section 11) until the Enrollee has had continuous coverage under the previous group policy and this Certificate combined for a period of 12 months from an Enrollee's effective date of coverage under the prior employer group policy. This 12-month period is referred to as the "pre-existing period". If the Enrollee submitted an application for coverage during their initial Waiting Period under the prior employer group policy, the pre-existing period begins on the first day of the Waiting Period. If the Enrollee did not apply for coverage within the Waiting Period, the pre-existing period begins on the Enrollee's original effective date under the prior employer group policy.

9.1 Periods of Creditable Coverage

Periods of Creditable Coverage (as defined in applicable law and regulations) will reduce the Pre-existing Condition exclusion period. For purposes of this Certificate, Creditable Coverage includes the coverage an Enrollee had under the prior employer group policy. The notification an Enrollee receives from us sets out the Enrollee's Pre-existing Condition period as calculated by us. In reaching this determination, we consider Certificates of Creditable Coverage provided by the Enrollee's prior health plans and health insurers as well as information otherwise available to us.

Failure to cooperate fully shall constitute grounds for affirming any original Pre-existing Condition exclusion period determination, and denying Claims on that basis.

9.2 Applicability of Pre-existing Exclusion

This Pre-existing Condition exclusion is not applicable to:

1. Pregnancy if you or your enrolled spouse is pregnant as of the effective date of this Certificate; or
2. An Enrollee under the age of 19.

9.3 Request for Reconsideration of Pre-existing Condition Limitation Period Determination

How to request a reconsideration of a Pre-existing Condition Limitation Period Determination:

1. If an Enrollee disagrees with the Pre-existing Condition limitation period calculated by us, the Enrollee can ask for a reconsideration of this determination by sending a written request to:

   Enrollment Department
   QualChoice
   P.O. Box 25610,
   Little Rock, AR 72221-5610

2. An Enrollee's request for reconsideration must include a written statement of the correct period of time the Enrollee had Creditable Coverage and relevant evidence to corroborate the Enrollee's statement. Relevant evidence can include Certificate(s) of Creditable Coverage issued by prior health plans, explanation of benefits, claims or other correspondence from a health plan indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a benefit certificate, or the telephone number of the Member's prior heath plan.
3. By requesting reconsideration of the determination of a Pre-existing Condition limitation period, the Enrollee agrees to cooperate with efforts to verify prior coverage. Cooperation includes, but is not limited to, providing written authorization to request a certificate on the Enrollee's behalf from prior health plan(s) and insurer(s), providing information about the Enrollee's prior health plan(s) and insurer(s), such as telephone numbers and addresses, and assisting the efforts to determine the validity of the corroborating relevant evidence.
4. We will make our final determination of an Enrollee's Pre-existing Condition limitation period within a reasonable period of time after it receives the Enrollee's written request for reconsideration.
5. Appeals from a denial of a Claim based on the Pre-existing Condition exclusion (as distinguished from appeals concerning the calculation of the Pre-existing Condition limitation period) should follow the general appeal procedures outlined in Section 9.

10. GENERAL PROVISIONS

10.1 Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under this Certificate. If we do so, we will give thirty (30) days written notice to you and the change will go into effect on the date fixed in the notice.

10.2 Assignment

You cannot assign any Benefits or monies due under this Certificate to any person, corporation, organization or other entity. Any assignment by you will be void and have no effect. Assignment means the transfer of your right to the Benefits provided under this Certificate.

10.3 Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. Notice to us must be in writing and mailed to our offices at:

QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

10.4 Your Medical Records

We may need to obtain copies of your medical records from any of your treating providers. This may be necessary to properly administer your Benefits. You, or your legal representative, agree to sign an appropriate authorization for release of medical records upon our request. If you elect not to consent to the release of medical records, we may be unable to properly administer your coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

10.5 Request for Certificate of Creditable Coverage

You may request from us at any time a Certificate of Creditable Coverage by contacting our Customer Service Department.

10.6 Notice of Claim

We must receive your Claim for Benefits within no more than 12 months from the date you receive the service. Failure to meet this requirement will result in payment denial.

10.7 Who Receives Payment Under This Certificate

We will make payments under this Certificate directly to the Network Providers providing care.

10.8 Recovery of Overpayments

On occasion, an incorrect payment may be made to you. Reasons for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem to you in writing. You must return to us within 60 days the amount of the mistaken payment. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

10.9 Confidentiality

Medical records and other information concerning your care we receive from providers are confidential. We will use such information only to administer your coverage. We will only disclose such information as required to coordinate Benefits or assure continuity of care. Other disclosures require your written consent. See your Notice of Privacy Practices for a more detailed description of your privacy rights and duties.

10.10 Complaint and Appeals
You are entitled to have any complaints heard by us. We are obligated to hear and resolve such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures for complaints and appeals set forth in Section 9 will be followed.

10.11 Right to Develop Policies and Guidelines
We reserve the right to develop or adopt policies and guidelines for the administration of Benefits under this Certificate. These policies and guidelines will be interpretive only and will not be contrary to any terms of this Certificate. If you have a question about the policies or guidelines used to apply to a particular Benefit, you may contact us or visit our website at www.qualchoice.com for further information.

10.12 Limitation on Benefit of This Certificate
No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Certificate. The covenants, undertakings, and agreements set forth in this Certificate shall be solely for the benefit of our Enrollees and us.

10.13 Applicable Law
This Certificate, the rights and obligations of our employees and us under this Certificate, and any claims or disputes relating thereto, shall be governed by and construed in accordance with Federal and Arkansas law.

10.14 Headings
Section and subsection headings contained in this Certificate are inserted for convenience of reference only. They shall not be deemed to be part of this Certificate for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

10.15 Pronouns
All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

10.16 Severability
If any part of any provision of this Certificate or any document or writing given pursuant to or in connection with this Certificate shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Certificate.

10.17 Waiver
The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Certificate shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Certificate or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

11. DEFINITIONS
There are other definitions, usually capitalized, contained in various sections throughout this Certificate. The capitalized words or terms used in this Certificate and are not otherwise defined have the meanings set forth below:

11.1 **"Accidental Injury"** means a bodily injury (other than intentionally self-inflicted injury) happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent

of disease or bodily infirmity. Accidental Injury to teeth does not include any damage caused by chewing or biting any object.

11.2 **"Benefits"** means reimbursement or payments for health care available to Enrollees covered under this Certificate.

11.3 **"Benefits Summary"** means a document containing specific information relating to your coverage and Cost Sharing Amounts under this Certificate. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum benefits as well as visit and day maximums for limited services.

11.4 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

11.5 **"Certificate"** means this conversion medical benefits policy through which Benefits are provided, in whole or in part, as reflected in this Certificate.

11.6. **"Certificate Holder"** means you, the person to whom this Certificate is issued.

11.7 **"Child"** means the Certificate Holder's natural child, legally adopted child, child for whom the Certificate Holder is the legal guardian, or stepchild. "Child" also includes a child for whom the Certificate Holder is the adoptive parent during the Waiting Period prior to completing the adoption. Foster children are not included in the definition of "Child".

11.8 **"Claim for Benefits" or "Claim"** means (i) a request for payment or prior approval (when required under the Certificate) for a service, supply, medication, equipment or treatment covered by the Certificate, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee's authorized representative, and (iii) is submitted consistent with QualChoice's standard claim filing policies and procedures (copies of which are available on request).

11.9 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge you must pay toward the cost of certain Covered Services. Those Covered Services subject to the application of Coinsurance are identified in your Benefits Summary. Coinsurance is subject to an annual maximum limit.

11.10 **"Complication of Pregnancy"** means a condition requiring facility confinement, when the pregnancy is not terminated, the diagnosis of which is unrelated to the pregnancy but causes the mother's health to be adversely affected. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity which threaten the mother's health or life.

The following will also be considered a Complication of Pregnancy:

1. A c-section occurring after failure of a trial of labor;
2. An emergency c-section required because of fetal or maternal distress during labor;
3. An ectopic pregnancy which is terminated;
4. A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and
5. A non-scheduled c-section.

11.11 **"Co-payment"** means a fixed dollar amount you must pay each time you receive a particular Covered Service to which a Co-payment applies.

11.12 **"Cost Sharing Amount"** means an amount you are required to pay each time you receive a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in your Benefits Summary.

11.13 **"Covered Dependent"** means any member of the Certificate Holder's family who meets the eligibility requirements of Section 5, who is enrolled in the Certificate, and for whom we have received premium.

11.14 **"Covered Service(s)"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Certificate. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the definition of "Medically Necessary" in this section and the other qualifications set forth in Section 3.

11.15 **"Custodial Care"** means provision of routine care that is primarily for meeting personal needs, including assistance with activities of daily living.

11.16 **"Deductible"** means a certain fixed dollar amount you must incur before we begin to pay for the cost of Covered Services provided to you during each Calendar Year. Each Enrollee must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.

11.17 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

11.18 **"Enrollee"** means a Certificate Holder and any spouse of a Certificate Holder or dependents of the Certificate Holder or of the Certificate Holder's spouse covered under this Certificate.

11.19 **"Enrollment Application"** means the form to be accurately completed by prospective Certificate Holders when they apply for enrollment.

11.20 **"High Dose Chemotherapy"** means Chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., granulocyte, colony-stimulating factor, granulocyte-macrophage colony-stimulating factor, reinfusion of stem cells, reinfusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any Enrollee who received this High Dose Chemotherapy, to prevent life threatening complications of the chemotherapy on the Enrollee's own blood cells.

11.21 **"Injectible Prescription Medications"** means any injectible pharmaceutical that has been approved by the Food and Drug Administration.

11.22 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits under this Certificate are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much your health care provider may bill for a given service, the Benefits under this Certificate will be limited by the Maximum Allowable Charge we establish. If you use a QualChoice Network Provider and QualChoice is the primary payor, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, **if you use an Out-of-Network Provider you will be responsible for all amounts billed**.

11.23 **"Medical Advisory Committee"** means an internal committee composed of practicing physicians selected by QualChoice from the Arkansas medical community.

11.24 **"Medical Policy" or "Medical Policies"** means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit certificate or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

11.25 **"Medically Necessary" or "Medical Necessity"** means a Covered Service, which in the opinion of our medical personnel:

A. Provides for the diagnosis or treatment of the Enrollee's covered medical condition;
B. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's illness, injury or medical condition in relation to any overall medical/health conditions;
C. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
D. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
E. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

11.26 **"Mental Health or Substance Use Disorder"** means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & Statistical Manual of Mental Diseases of the American Psychiatric Association (DSM) classification.

11.27 **"Network Facility"** means a hospital facility or other facility (e.g., hospice, ambulatory surgery center, etc.) that has entered into an agreement with us to make Covered Services available to Enrollees.

11.28 **"Network Primary Care Physician"** means a physician who has entered into an agreement with us regarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilized by an Enrollee as his or her primary care physician. The following will be considered to be a primary care physician: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

11.29 **"Network Provider"** means a Network Primary Care Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

11.30 **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with us regarding, among other things, willingness to provide specialty Covered Services to Enrollees and who may be utilized by an Enrollee as his or her specialty physician. The following will not be considered to be a specialist: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

11.31 **"Out-of-Network Provider"** means a physician, facility or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees. Regardless of any other provision in this Certificate, the extent of QualChoice's coverage for services provided by an Out-of-Network Provider is as set forth in your Benefits Summary.

11.32 **"Out-of-Pocket Limit"** means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

11.33 **"Pre-existing Condition"** means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on (1) the Member's effective date with the Certificate or (2) the first day of their Waiting Period, as applicable. The period is calculated by counting back from the first day of the Waiting Period, rather than from the Member's actual effective date. If the Member does not apply within the Waiting Period, the 6-month period is calculated by counting back from the Member's effective date of coverage.

Notwithstanding the definition above, with respect ONLY to an Enrollee who is under nineteen (19) years of age, "Pre-existing Condition" means a condition that was present before the effective date of coverage, or if coverage is denied, the date of the denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day.

A preexisting condition can be identified through information relating to health status before the Enrollee's effective date of coverage or if coverage is denied, the date of the denial, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the Enrollee, or review of medical records relating to the pre-enrollment period.

Moreover, the definition above does not include an Enrollee's pregnancy in existence on the effective date of this Certificate.

11.34 **"Referral"** means a specific written approval from us that an Enrollee seeks for additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Certificate. We issue Referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you are completed during the appropriate period. There will be no coverage for services rendered outside the approved period.

11.35 **"Service Area"** means the geographical area in which we are licensed by the State of Arkansas to conduct business.

11.36 **"Waiting Period"** means the period from your date of hire until the date you were first eligible for coverage under your employer group policy.

Michael E. Stock, President & CEO
QCA Health Plan, Inc.
The QualChoice Building
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

Amendment to Conversion Evidence of Coverage (Form # QCA HMO (01-01-05)

Attached is the Benefits Summary indicating name, benefits, Out-of-Pocket Limit amount, type of coverage, Preexisting Condition exclusion period, and effective date.

IMPORTANT NOTICE

COVERED SERVICES RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN VERY LIMITED CIRCUMSTANCES AS SET FORTH IN YOUR BENEFITS SUMMARY ARE NOT COVERED. REFER TO YOUR BENEFITS SUMMARY.

THIS COVERAGE CONTAINS A PREEXISTING CONDITION LIMITATION. REFER TO THE BENEFITS SUMMARY.

The benefits in this Certificate do not necessarily equal or match those benefits provided in your previous group policy.

Underwritten by:

QCA Health Plan, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
www.qualchoice.com

IMPORTANT QUALCHOICE CONTACT INFORMATION

QualChoice is committed to providing better customer support. That includes making it easy for you to contact us. You are always welcome to call us with any questions or concerns.

Website Address:

www.qualchoice.com

Our Customer Service Department can be reached:

Toll Free at (800) 235-7111

Locally at (501) 228-7111

Our QCARE Coaches can be reached:

Toll Free at (888) 795-6810

Our "Ask a Nurse" assistance line can be reached:

Toll Free at (866) 232-0447

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1. INTRODUCTION TO YOUR AMENDED CERTIFICATE

1.1. Certificate

QCA Health Plan, Inc. Inc. ("QualChoice" also referred to as "us", "we" or "our") is a licensed Health Maintenance Organization. QualChoice has a certificate of authority from the Commissioner of Insurance of the State of Arkansas. We are located at 12615 Chenal Parkway, Suite 300, Little Rock, Arkansas 72211. Our telephone number is (501) 228-7111 or toll free (800) 235-7111.

This is your Amendment to the Conversion Evidence of Coverage Certificate (Form # QCA HMO (01-01-05)) (the "EOC"). The Amendment modifies the EOC as set forth in herein. To the extent there is conflict between this Amendment and the EOC, this Amendment will control. This Amendment shall be referred to hereinafter as the "Certificate".

This Certificate is a legal document between QCA Health Plan, Inc. and you to provide Covered Services subject to the terms, conditions, exclusions and limitations included herein.

1.2. Changes to This Certificate

We may from time to time modify this Certificate through a "Rider" and/or "Amendment" that may change certain provisions of this Certificate. When this happens we will send you a new Certificate, Rider or Amendment.

1.3. Key Information

For purposes of this Certificate, "you" or "your" means the Certificate Holder.

Only we have the right to change, interpret, modify, withdraw or add Benefits, or terminate this contract, as permitted by law, without your approval.

On its effective date, this Certificate replaces and overrules any certificate that we may have previously issued to you. This Certificate will in turn be overruled by any certificate we issue to you in the future.

Your coverage under this Certificate begins at 12:01 a.m. on the effective date, which is the day following the termination of your coverage under the employer group policy. We will continue your coverage unless and until you or we terminate it for any of the reasons described in this Certificate. We determine your eligibility for Benefits under this Certificate.

This Certificate and Benefits Summary describe your Benefits, conditions, limitations, exclusions and Cost Sharing Amounts. The Benefits Summary provided to you is an integral part of this Certificate. In the event this Certificate and the Benefits Summary conflict, the Benefits Summary will control. You should locate and familiarize yourself with the Benefits Summary.

This Certificate describes some special procedures with which you must comply.

To the extent that state law applies, the laws of the State of Arkansas shall govern this Certificate.

We have capitalized certain words in this Certificate. Those words have special meanings and, unless defined otherwise elsewhere, are defined in Section 11, "Definitions".

2. HOW THIS PLAN WORKS

This Certificate provides you with a flexible choice in selecting options in obtaining health care services and how your choice may financially impact you. We encourage you to utilize a Network Primary Care Physician to assist in the coordination of your health care services under this Certificate. The utilization of a Network Primary Care Physician is a matter you control and you are not required to notify us of your Network Primary Care Physician relationship. You are always encouraged to seek care directly from a Network Primary Care Physician first. You may also seek care with any Network Physician or Provider under this Plan without a Referral. Consult your Benefits Summary to identify Covered Services and Cost Sharing amounts.

2.1 In-Network Benefits

In-Network Benefits are Covered Services which are either:

1. Provided by or under the direct supervision of a Network Provider or at a Network Facility; or
2. Emergency health services meeting the QualChoice payment guidelines.

Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and meets either of these requirements will be processed as an In-Network Benefit. Subject to all terms, conditions, exclusions, and limitations set out in this Certificate, a service that is a Covered Service and does not meet either of these requirements will not be covered.

You should validate the status of a Network Provider by accessing the on-line directory at any time or calling Customer Service during normal business hours.

Please note that certain Covered Services may only be obtained from a Network Provider. Such Covered Services are identified in your Benefits Summary.

You may seek Covered Services from any Network Primary Care Physician or from other Network Physicians without a Referral. Coverage for services in the office is at the primary care physician benefit level when you seek Covered Services directly from any Network Primary Care Physician. Coverage for services in the office is at the specialist benefit level when you seek Covered Services from any other Network Physician. You should validate the status of a Network Provider by calling Customer Service or accessing the on-line provider directory. Please refer to your Benefits Summary for details.

2.2 Out-of-Network Benefits

As described in your Benefits Summary, services provided by an Out-of-Network Provider are not covered unless otherwise stated in your Benefits Summary or unless prior authorization for coverage as an In-Network Benefit is received from us. Any amounts that QualChoice allows for Covered Services provided by an Out-of-Network Provider will be subject to the Maximum Allowable Charge. You will be responsible for the applicable Cost Sharing Amounts related to such Covered Services and the difference between the charges billed by the Out-of-Network Provider and the Maximum Allowable Charge. Please refer to your Benefits Summary for details:

1. **Certificate Provision:** The Benefits Summary or this Certificate specifically provides a different Deductible, Coinsurance or Out-of-Pocket Limit for the particular service or supply that is the subject of the claim;
2. **Emergency Services:** The intervention is for an Emergency in which case the In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit apply;
3. **Continuity of Care, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage, you were scheduled with an Out-of-Network Provider for a procedure or ongoing treatment covered under the terms of this Certificate, that such procedure or treatment is for a condition requiring immediate care, and that you request In-Network Benefits for such scheduled procedure or ongoing treatment. If QualChoice approves In-Network Benefits for the scheduled procedure or ongoing treatment, In-Network Benefit Deductible, Coinsurance, and Out-of-Pocket Limit will apply to claims for services and supplies rendered by the Out-of-Network Provider for such condition after QualChoice's approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
4. **Continuity of Care, Pregnancy, Prior to Coverage:** You notify QualChoice that prior to the effective date of your coverage you were receiving obstetrical care from an Out-of-Network Provider for a pregnancy covered under the terms of this Certificate, that you were in the third trimester of your pregnancy on the effective date of your coverage, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefit Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits;
5. **Provider Leaves Network:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition began and that you request In-Network Benefits for the continuation of such ongoing treatment. If

QualChoice approves In-Network Benefits for the requested ongoing treatment, In-Network Deductible, Coinsurance and Out-of Pocket Maximum will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;

6. **Provider Leaves Network, Pregnancy:** You notify QualChoice that your Out-of-Network Provider was formerly an In-Network Provider when you began receiving obstetrical care for a pregnancy covered under the terms of the Certificate, that you were in the third trimester of your pregnancy on the date that the Provider left the PPO, and that you request In-Network Benefits for continuation of such obstetrical care from this Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested obstetrical care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider after QualChoice's approval and will continue to apply to claims for services and supplies rendered by the Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits; or
7. **Prior Authorization:** You notify QualChoice prior to seeking services of the absence of or the exhaustion of all In-Network resources for a Covered Service resulting in the need to seek care from an Out-of-Network Provider. If QualChoice approves In-Network Benefits for the requested care, In-Network Benefits Deductible, Coinsurance and Out-of-Pocket Limit will apply to claims for services and supplies received from this Out-of-Network Provider until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first.

Note: Notification to QualChoice of requests for payment of an Out-of-Network Provider services or supplies at In-Network Benefit level must be made by writing QualChoice, Attn: Care Management, P.O. Box 25610, Little Rock, AR 72221 or by faxing the request to (501) 228-9413, and must be received at least five (5) working days prior to your receipt of such services or supplies.

2.3 Network Provider Participation

We publish an online directory listing of physicians, facilities, and other healthcare providers who have contractually agreed to provide Covered Services to Enrollees and have them reimbursed at an In-Network Benefit level. You may search the directory on our website at www.qualchoice.com. Because contractual agreements can change, you should verify that a physician or provider is a Network Provider before you seek care.

We provide no express or implied warranties or guarantees with respect to any Network Provider or the professional services provided by such provider. The utilization of a Network Provider or any other provider and the decision to receive or decline to receive health care services is your responsibility.

If you have a medical condition that we believe needs special services, we may direct you to an appropriate facility or other provider. If you require certain complex Covered Services for which expertise is limited, we may direct you to an Out-of-Network Provider. **In both cases, In-Network Benefits will only be paid if your Covered Services for that condition are approved by us prior to receiving the service.** We will not cover any services not specifically authorized by us in the written statement of authorization. The following do not constitute approval for Benefits:

1. A referral, whether written or oral, by a Network Provider to an Out-of-Network Provider; or
2. An order or prescription for services to an Out-of-Network Provider.

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your availability to Network Providers may be limited. If this happens, we may require you to utilize a single Network Provider to provide and coordinate all future Covered Services. If you do not make a change to a single Network Provider within 31 days of the date we notify you, we will assign a single Network Provider to you.

2.4 Cost Sharing Requirements

You must share in the cost of your Covered Services through Co-payments, Coinsurance, and Deductibles, or combinations of these Cost Sharing Amounts. Consult your Benefits Summary to determine the amounts of your payments under these Cost Sharing Amounts. A Network Provider may bill you directly for Co-payments, Coinsurance and Deductible amounts, but may not bill you for the difference between his or her customary charge and the Maximum Allowable Charge. An Out-of-Network Provider may bill you directly for all charges. **These additional charges could amount to thousands of dollars in additional out-of-pocket expenses for which you are responsible.**

1. **Deductible:** The Deductible is a certain fixed dollar amount per Calendar Year, per person as set forth in your Benefits Summary.
2. **Co-payment:** A Co-payment is a fixed dollar amount you must pay each time you receive a Covered Service to which a Co-payment applies. Co-payment amounts do not apply to the satisfaction of the Deductible amounts or Out-of-Pocket Limits for each Enrollee or family. Please see your Benefits Summary for a list of those Benefits to which Co-payments apply.
3. **Coinsurance:** Coinsurance is a fixed percentage of the Maximum Allowable Charge for the cost of Covered Services you must pay. Coinsurance payments are in addition to Deductibles or Co-payments. Your Benefits Summary contains your Coinsurance percentage applicable to specific Benefits. You are responsible for paying the amount of the applicable Coinsurance for the Covered Services provided to you.
4. **Limits on Your Out-of-Pocket Payments:** You will no longer have to pay Coinsurance for the remainder of the Calendar Year after you have met the Out-of-Pocket Limit during the Calendar Year. Your Benefits Summary lists your Out-of-Pocket Limit for Coinsurance. Coinsurance is the only amount that will apply towards your Out-of-Pocket Limit. Co-payments, Deductibles, or charges in excess of the Maximum Allowable Charge are your responsibility and do not count toward meeting the Out-of-Pocket Limit. Once your Out-of-Pocket Limit has been satisfied, you will still be responsible for charges in excess of our Maximum Allowable Charge.

2.5 Medically Necessary Services

"Medically Necessary" or "Medical Necessity" means a Covered Service which in the opinion of our medical personnel:

1. Provides for the diagnosis or treatment of the Enrollee's covered medical conditions;
2. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's specific illness, injury or medical condition in relation to any overall medical/health conditions;
3. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
4. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
5. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

Regardless of anything else in this Certificate, and regardless of any other communications or materials you may receive in connection with your Certificate, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs if QualChoice finds it to be not Medically Necessary. All determinations of Medical Necessity for Covered Services are made in accordance with the above definition at the sole discretion of QualChoice.

We reimburse only for Medically Necessary Covered Services as defined in . This standard applies to all sections of this Certificate.

If we determine a service is not Medically Necessary before or after a Network Provider renders it, we prohibit the Network Provider who rendered the service from billing you for the service unless you agreed in writing to be responsible for payment before the service was provided.

If we determine a service is not Medically Necessary before or after an Out-of-Network Provider has rendered it, you will be responsible for the charges for services which are determined not to be Medically Necessary.

We make a determination of Medical Necessity after considering the advice of trained medical professionals, including physicians, who may use medically recognized standards and criteria. In making the determination, we will examine the circumstances of your condition and the care provided, including the reason your provider prescribed or provided the care, and any unusual circumstances, which necessitate attention. However, the fact your physician prescribed the care or service does not automatically mean the care is Medically Necessary or it qualifies for payment under this Certificate. A medical treatment that meets the criteria for Medical Necessity will still not be reimbursed if the condition being treated is excluded from coverage as set forth in Section 4.1.

2.6 Exclusion and Limitations

Some services are excluded from coverage and other services have specific coverage limitations.

This Certificate refers to Medical Policies we have developed that may limit or exclude coverage for a particular service, treatment or drug. You may contact our Customer Service Department to request a copy of our Medical Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Medical Policies on our web site at www.qualchoice.com.

Consult your Benefits Summary, Medical Policies, and Section 4.0 for information on benefit limitations and exclusions.

2.7 Enrollees Living Outside Service Area For More Than 90 Days

Enrollees that will live, work, or attend school outside the Service Area for more than 90 consecutive days should notify us. The Enrollee uses his/her QualChoice identification card to access Covered Services. Covered Services are processed at the In-Network Benefit level when provided by a QualChoice National Network (QCNN) healthcare provider. Covered Services for services not provided by a QualChoice National Network (QCNN) provider are will not be covered.

Enrollees who may use the QCNN for In-Network Benefits are:

1. Dependent students who are attending school outside the Service Area for at least 90 consecutive days, with renewal required annually; or
2. Dependent spouses and children who are living outside the Service Area for at least 90 consecutive days, with renewal required annually.

Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization for those services that we require to be pre-authorized (see Section 2.11) to receive Benefits at the In-Network Benefit level when accessing care from the QualChoice National Network (QCNN). It is the responsibility of the Enrollee to obtain the pre-authorization for Covered Services. QCNN providers are not responsible for obtaining a pre-authorization for services.

2.8 Coverage While Traveling Out of the Service Area

We cover the cost of Emergency health services an Enrollee incurs while traveling outside of the Service Area, but within the United States. An Enrollee is encouraged to seek services for Emergency health services from health care providers participating in the QualChoice National Network (QCNN) when the Enrollee is out of the Service Area. An Enrollee may limit out-of-pocket expenses for Emergency health services while outside of the Service Area to applicable Cost Sharing Amounts by accessing such care from a QCNN provider.

If care is accessed by an Enrollee from providers not participating in the QCNN, Covered Services received from such providers are not covered except in very limited circumstances as set forth in you Benefits Summary. We will deny coverage for routine and follow up care after Emergency health services unless a Network Provider in Arkansas performs the services.

The QualChoice identification card contains contact information for the QCNN. QCNN providers may be identified by calling the number on the identification card. The Enrollee must present their QualChoice identification card to the servicing provider indicating participation in the QCNN in order to receive this benefit. Submit a Claim for Benefits directly to us for processing. Provisions for Emergency health services as set forth in Section 3.10 must also be followed to receive maximum Benefits.

Dependents who have notified QualChoice that they reside outside the Service Area may access the QCNN providers and facilities for Covered Services at the In-Network benefit level upon prior approval by QualChoice.

2.9 General Conditions for Payment

Payment for Covered Services is subject to the Enrollee's eligibility on the date such services are rendered, and to all conditions, limitations, and exclusions of this Certificate. A final determination of eligibility is made at the time a Claim is received by us. Determination of non-eligibility subsequent to the payment of services as a result of error or fraud will result in recovery of such payments made by us. Benefits are provided only if services provided were ordered by a healthcare care provider, provided within the scope of that healthcare provider's license, and rendered in accordance with professionally recognized standards of care.

During the first year of this Certificate, the Benefits payable under this Certificate shall not exceed those that would have been payable had your Benefits under your former employer's group policy remained in force and effect.

2.10 Administration and Interpretation of this Certificate

We have sole and exclusive discretion to interpret the Benefits provided under this Certificate as well as all other provisions, terms, conditions, limitations and exclusions in the Certificate and to make factual determinations related to the Certificate and its Benefits. We may delegate this authority to other persons or entities to provide administrative or Benefit services with regard to this Certificate. Subject to applicable law or regulation we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate the Certificate, in our sole discretion, without prior notice to or approval by Enrollees. Changes to this Certificate will be valid or binding only if in writing and agreed to by an officer of QualChoice.

2.11 Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medically Necessary. We must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

QualChoice requires that certain Covered Services must be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on our web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

Your responsibility for obtaining pre-authorization varies depending on whether you use a Network Provider or an Out-of-Network Provider. Network Providers (not including QCNN providers) are responsible for obtaining the necessary pre-authorizations for you. Enrollees living outside of the Service Area will be responsible for obtaining pre-authorization to receive Benefits at the In-Network level when accessing care from the QualChoice National Network (QCNN). QCNN providers are not responsible for obtaining a pre-authorization for services. Out-of-Network Providers have no contractual relationship to QualChoice, and therefore are not responsible for obtaining required pre-authorizations.

Pre-authorization is not a guarantee of payment. Even though pre-authorized, payment may not be rendered for any service if your clinical status has changed sufficiently that the service is no longer medically appropriate. Your coverage with QualChoice must be in force on the date of service or no payment will be made. You may request a pre-review of coverage for any service by calling our Customer Service department. Any of our pre-authorization decisions may be appealed by following the procedures in Section 7. Your physician may request an Expedited Appeal of a denial of a pre-authorization by calling the number on your QualChoice identification card if your physician believes the services are urgent due to your medical condition.

2.12 Utilization Management

We cover Medically Necessary services as described in Section 2.5. Determinations of Medical Necessity are made using QualChoice's Medical Policies. We make decisions regarding whether a particular service is or was Medically Necessary based on information provided by your Network Provider(s). When we review services after care has already been provided, we may review your medical records. A Network Provider may request the criteria or guidelines used by QualChoice in making any decision.

2.13 Case Management

We provide a Case Management program. Case Management assists you to make the best use of your Benefits. Case Management helps with an individual's specific health care needs. Case Management involves the timely coordination of health care services. We review clinical information before we include any Enrollee in the Case Management program. We stay involved in the case until the need is resolved. Enrollees may participate in Case Management programs including programs for diabetes mellitus, high-risk pregnancy, transplants, oncology and neonatology.

2.14 QCARE

QCARE is our population health management program that facilitates access to medical services, and provides tools and self-management assistance to our Enrollees who have chronic medical conditions, such as diabetes, hypertension, and asthma. We work one-on-one with Enrollees to help them understand their illnesses better. We also educate Enrollees on treatment options so that the Enrollee can better manage their health.

3. COVERED MEDICAL BENEFITS

Coverage is available for medical services or care as specified in this section subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11, and to all other applicable conditions, limitations and exclusions of this Certificate. **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.1 Advanced Diagnostic Imaging

Advanced diagnostic imaging consists of the following studies (though others may be added as new studies are developed):

1. All imaging using Computerized Axial Tomography (CAT) technology;
2. All imaging using Magnetic Resonance Imaging (MRI) technology;
3. All imaging using Positron Emission Tomography (PET) technology;
4. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:

1. Regardless of where they are performed, they always fall under the required Cost Sharing Amounts of your Certificate as set forth in your Benefits Summary; and
2. Pre-authorization is required for these tests. The requirements for pre-authorization are detailed in Section 2.11 must be referred to and followed when receiving any of the Advanced Diagnostic Imaging studies.

3.2 Ambulance Services – Transportation

We cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations as set forth in this Certificate. This benefit is subject to the Cost Sharing Amounts and benefit limitations specified in your Benefits Summary, and the following criteria:

1. When an accident or other medical Emergency occurs, we cover transport to the nearest facility when Emergency services are required;
2. We cover ambulance transportation from one facility to another facility for one of the reasons identified below as long as it is coordinated through the QualChoice Care Management department:
    A. To access equipment or expertise necessary to care for you properly;
    B. To receive a test or service which is not available at the facility where you have been admitted and you return after the test or service is completed;
    C. To transport you from an Out-of-Network Facility to a Network Facility; and
    D. To transport you directly from an acute care setting to an alternate level of care.

3.3 Complications of Pregnancy

Coverage is provided for treatment of Complications of Pregnancy when performed or prescribed by a physician subject to the Deductible and Coinsurance amounts specified in the Benefit Summary.

3.4 Dental – Accidental Injury

We will provide coverage if an Enrollee has an Accidental Injury that damages a sound, natural tooth. Treatment must be authorized by QualChoice prior to services being provided. Benefits are subject to a maximum limit per Enrollee per accident. See your Benefits Summary for the limitation. Dental services must be received from a Doctor of Dental Surgery ("D.D.S.") or a Doctor of Medical Dentistry ("D.M.D."). The damage must be severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

The physician or dentist must certify that the injured tooth was:

1. A virgin or un-restored tooth; or
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with any bone loss, or no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must be started within three months of the original accident date and completed within 12 months of the original accident date.

If the Enrollee is under age 15, reimbursement for dental care services provided after such twelve (12) month period will be provided if: (a) such reimbursement is requested within such twelve (12) month period, (b) the request for reimbursement is accompanied by a plan of treatment, (c) in the opinion of QualChoice, under standard dental practices the treatment could not have been provided within such twelve (12) month period and (d) coverage for the injured Enrollee is in force when the treatment is rendered.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. The following limitations for treatments also apply to repair of damaged teeth:

1. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the Accidental Injury will be considered for replacement;
2. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position; reimbursement for this service will be based upon a Maximum Allowable Charge per tooth;
3. Double abutments are not covered;
4. Any health intervention related to dental caries or tooth decay is not covered;
5. Removal of teeth is not covered; and
6. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

3.5 Dental – Anesthesia

QualChoice will provide Benefits for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

1. The procedure is performed in a Network Facility; and
2. The situation meets Medical Necessity criteria, and the patient is:
    A. A Child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible;
    B. A person with a serious mental health condition that prevents use of local anesthesia for the procedure;
    C. A person with a serious physical condition making facility care necessary for the safe performance of dental work; or
    D. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other Covered Services will apply. Pre-authorization is required (see Section 2.11). **Consult your Benefits Summary for applicable Cost Sharing Amounts.**

3.6 Dental – Oral Surgery

QualChoice will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required;
2. Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered;
3. Excision of exostoses of jaws and hard palate;
4. Extraction of teeth is required because of the results from radiation or chemotherapy;
5. Frenectomy;
6. External incision and drainage of cellulitis; and
7. Incision of accessory sinuses, salivary glands or ducts.

3.7 Dental – Other

Other dental care and orthodontic services are not covered.

3.8 Diabetes Management

Diabetes self-management training is limited to one program per lifetime per Enrollee. If there is a significant change in the Enrollee's symptoms or condition making it necessary to change the Enrollee's diabetic management process, we may authorize additional training if prescribed by a physician. Covered Services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

3.9 Durable Medical Equipment

Durable Medical Equipment (DME) is equipment primarily and customarily serving a medical purpose, is non-disposable, can withstand repeated use, is appropriate for use in the home, and is generally not useful in the absence of the illness or injury for which it is used. DME is subject to Medical Necessity and appropriateness review. We will not cover DME if primarily used for the convenience of the Enrollee or any other person.

You must obtain all DME through a Network Provider. All DME remains the property of QualChoice or a Network Provider. When it is more cost effective, we will purchase rather than lease equipment. The amount paid for leasing a DME item will not exceed the Maximum Allowable Charge for purchase. We retain the right to recover any equipment purchased by us for the use of the Enrollee upon cancellation or termination of coverage for the Enrollee. Delivery or set up charges are included in the Maximum Allowable Charge for the DME.

Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Enrollee.

The definition of and description of coverage for orthotics and prosthetic devices and services are in Sections 3.22 and 3.27 below.

Important Note: DME dispensed by a physician in an office setting and billed by a DME provider must be provided through a Network DME Provider. It is your responsibility to confirm this with your physician. If DME dispensed by your physician is not from a Network DME Provider, you can obtain a prescription from your physician for the DME and contact us to assist in obtaining the equipment. Failure to insure all DME is obtained from a Network DME Provider will result in denial of Benefits.

3.10 Emergency Health Services

We cover emergency room services that meet the definition of "Emergency" as set out in Section 11.

1. **Emergency Care within the Service Area:** An Enrollee is encouraged to seek care from a Network Provider in the event of an Emergency (as defined in Section 11) whenever possible. However, if in an Emergency an Enrollee is unable to access a Network Provider, the Enrollee should go to the nearest urgent or emergent care facility. Services provided in an Emergency are paid as shown in your Benefits Summary.
2. **Emergency Care outside of the Service Area:** Services provided in an Emergency when you are outside of the Service Area, but within the United States, are paid as shown in your Benefits Summary. Your QualChoice identification card provides a toll-free telephone number to call for a listing of healthcare providers in the QualChoice National Network (QCNN). QualChoice encourages you to seek treatment whenever possible from a healthcare provider in the QCNN.

If an Enrollee obtains services in an emergency room when the circumstances were not an Emergency, it will result in a denial of Benefits for the services provided. You have access to our "Ask a Nurse" assistance line at any time by calling the number at the front of this Certificate.

IMPORTANT IN THE EVENT OF AN ADMISSION AT AN OUT-OF-NETWORK FACILITY: If in an Emergency an Enrollee goes to an Out-of-Network Facility's emergency room for treatment and the Enrollee is admitted at that Out-of-Network Facility for further care or in-patient treatment, *the Enrollee, a family member or the Facility must notify our Care Management Department once the Enrollee is stabilized, but in no event more than forty-eight (48) hours after initial treatment*. Failure to notify us within the specified forty-eight (48) hour time requirement may result in a denial of Benefits. Upon receipt of such notification, we may either authorize the Enrollee's admission to, or further treatment at, the Out-of-Network Provider hospital, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Provider facility, the admitting physician, and the Enrollee's Network Provider. If the Enrollee stays at the Out-of-Network Facility beyond the period for which we have determined further treatment is considered Medically Necessary, you will be responsible for all charges billed by the facility and other Out-of-Network Providers providing care to you.

3.11 Eye Examinations

Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a Covered Service.

Benefits also include one routine vision exam, including refraction, to detect vision impairment by a Network Provider once every 24 months. Refraction is only covered when provided in conjunction with a routine vision examination.

Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery and for treatment of disease as specified in Section 4.1.

3.12 Family Planning Services
Coverage is provided for voluntary sterilizations (vasectomies and tubal ligations) except as excluded in Section 4.1

3.13 Home Health Services
Coverage is available for the following services provided in your home when your medical condition supports the need for such services, the services are ordered by a physician, and are pre-authorized by QualChoice.

We count each visit by a member of a home care team as one home care visit. (See your Benefits Summary for visit limitation details.)

The following services provided by a licensed home health agency in your home are Covered Services:

1. Intermittent skilled nursing care by a registered nurse or a licensed practical nurse. A service will not be determined to be "skilled" simply because there is not an available caregiver in the Enrollee's home; skilled care, that is, skilled nursing care provided by a registered nurse or licensed practical nurse under the supervision of a registered nurse, is not Custodial Care;
2. Physical, occupational and speech therapy services;
3. Medical supplies provided by the home health agency during the course of approved care; and
4. Home services by a nurse midwife, except home deliveries.

3.14 Home Infusion Therapy
The benefit for medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a home infusion therapy provider is covered based upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

1. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to Co-payment and/or Deductible and Coinsurance.
2. FDA approved medications that exist as separate components are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics, and hydration therapy and specialty infusions.
3. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.
4. When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

3.15 Hospice Services
Hospice services must be pre-authorized and arranged by a QualChoice Case Manager. Consult your Benefits Summary for applicable Cost Sharing Amounts. Coverage is available for Enrollees with a life expectancy of six months or less. Care must be provided by a hospice possessing all licenses, certifications, permits and approvals required by applicable federal, state and local law.

The following hospice services, when ordered by a physician, are covered during the period when the hospice has admitted an Enrollee to its program, provided the hospice program was pre-authorized by QualChoice:

1. In-patient care in a freestanding hospice, a hospice unit within a facility or skilled nursing facility, or in an acute care facility bed; and
2. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including, but not limited to, the following:
    A. Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides;
    B. Respiratory therapy;
    C. Social services;
    D. Nutritional services;
    E. Laboratory examinations;

F. Chemotherapy and radiation therapy when required for control of symptoms;
G. Medical supplies; and
H. Medical care provided by a physician.

3.16 Facility – In-patient Care

In-patient facility care Benefits are available for services and supplies received during the facility stay and room and board in a semi-private room (a room with two or more beds). We will not pay for any facility services unless the service is provided to the Enrollee by an employee of the facility, the facility bills for the service, the service is not primarily for convenience, and the facility retains the payment collected for the service.

Hospital in-patient care is also subject to the following conditions:

1. We cover Medically Necessary acute in-patient facility care for the care or treatment of the Enrollee's condition, illness, or injury;
2. The services of social workers and discharge planners shall be included in the basic daily room and board allowance.
3. Coverage is provided for a minimum of forty-eight (48) hours for an in-patient stay related to a mastectomy.
4. We do not provide Benefits while an Enrollee is waiting for Custodial Care;
5. We do not provide Benefits while waiting for a preferred bed, room, or facility;
6. The following applies when an Enrollee is waiting for transfer from an acute facility to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility, and long term acute care facility):
   A. The acute facility that the Enrollee is in awaiting a transfer should provide care equivalent to the care provided by the facility to which the Enrollee is waiting to be transferred;
   B. The days an Enrollee spends in the acute facility waiting for a transfer may count toward the limits for sub-acute and rehabilitation Benefits;
   C. We will pay the acute facility the Enrollee is in awaiting a transfer the lesser of that acute facility's rate or the rate at the facility to which the Enrollee is being transferred;
   D. If the acute facility the Enrollee is in awaiting a transfer is not providing the care we expect, we will deny those days and make no payment.

   .
7. Services rendered in a facility in a country outside of the United States of America shall not be paid except at the sole discretion of QualChoice.
8. Services to Out-of-Network Facilities are subject to pre-admission notification as described in Section 2.11. Please call the number listed on your identification card to notify us of the admission.

3.17 Injectible Prescription Medications

Benefits are available for Injectible Prescription Medication(s) received only when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility based upon the Maximum Allowable Charge for the Injectible Prescription Medication and subject to the applicable Cost Sharing Amounts specified in your Benefits Summary.

3.18 Infertility

Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. You may contact us to obtain specific coverage guidelines.

3.19 Maternity Services

The following maternity services are covered ***only*** if you or your enrolled spouse is pregnant as of the effective date of this Certificate:

1. **Fetal Testing:** Amniocentesis or chorionic villus sampling is covered when performed in accordance with recognized standards of care.

2. **In-patient Hospital Stays; Statement of Rights Under the Newborns' and Mothers' Health Protection Act.** Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any facility length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

   We will pay for an in-patient facility stay of at least 48 hours for the mother and newborn Child following a normal vaginal delivery. We will pay for an in-patient facility stay of at least 96 hours for the mother and newborn Child following a cesarean section delivery. However, we may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.
   Also, under federal law, we may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

   In addition, we may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact our Customer Service department.
3. **Maternity and Obstetrical Care:** Coverage is provided for Maternity and Obstetrical Care, including routine prenatal care, postnatal care, delivery in an in-patient facility setting, and any related complications. Routine prenatal care includes coverage of only one routine ultrasound usually done between the 16th and 22nd week of pregnancy. If additional ultrasounds are needed due to Medical Necessity, pre-authorization is required. QualChoice provides special prenatal programs designed to benefit you and your baby during pregnancy. These are available at no additional cost and are voluntary. To sign up, you should contact us as early as possible during your pregnancy.
4. **Midwives:** Coverage is provided for services received from a certified nurse midwife, but only if that nurse midwife is a Network Provider and the delivery is done in an in-patient facility setting.
5. **Newborn Care in the Hospital:** A newborn Child of the Certificate Holder or the Certificate Holder's spouse will be covered from the date of birth, including use of newborn nursery and related services, provided the Child's coverage becomes effective on his or her date of birth subject to the requirements of Section 5.0 being met.

3.20 Medical Foods

Medical foods and low protein modified food products for the therapeutic treatment of a person with phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism are covered if:

1. The medical food or low protein modified food products are prescribed by a Network Physician for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Network Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds $2,400 per year per person.

The covered amount will be the incurred cost of medical food or low protein modified food products that are in excess of the $2,400 per year per person, subject to the Cost Sharing Amounts specified in your Benefits Summary.

3.21 Medical Supplies

Medical supplies are items that are consumed or reduced with use so that they cannot be repeatedly used, are primarily or customarily used for medical purposes, and are generally not useful in the

absence of an illness or injury. Medical supplies do not include medications or implants. Medical supplies are only covered when prescribed by a physician and when Medically Necessary.

The following conditions will also apply to coverage for Medical supplies:

1. Coverage for medical supplies provided in a physician's office is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used;
2. Coverage for medical supplies provided in connection with home infusion therapy is included in the Maximum Allowable Charge for the procedure or service for which the supplies are used; and
3. Coverage for medical supplies is limited to a 31-day supply per month.

3.22 Orthotic Services and Orthotic Devices

Orthotic services and orthotic devices (as defined in this Section) are covered as described below.

All "orthotic devices" and "orthotic services", including the fitting and/or repair of orthotic devices, require pre-authorization as described in Section 2.11.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

In order for a device to be an "orthotic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

An orthotic device does ***not*** include a/an (i) cane, (ii) crutch, (iii) corset, (iv) dental appliance, (v) elastic hose, (vi) elastic support, (vii) fabric support, (viii) generic arch support, (ix) low-temperature plastic splint, (x) soft cervical collar, (xi) truss, or (xii) any similar device meeting both of the following requirements:

1. It is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does *not* include foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

Coverage for orthotic devices and orthotic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair an orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.23 Outpatient Services

Outpatient Covered Services are as follows:

1. Outpatient Facility Services: Subject to all of the terms, conditions, limitations and exclusions of this Certificate, Covered Services shall include services provided in a licensed outpatient facility or at a facility outpatient department. Examples include diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. We also cover up to 24 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for in-patient admission.

2. Outpatient Surgery: Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient facility setting when performed or prescribed by a physician. Covered Services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service.

We cover Medically Necessary surgical services. We apply multiple surgical procedures reduction when the same provider performs two or more surgical procedures on the same Enrollee within the same operative session.

3.24 Physician Office Services

The diagnosis and treatment of an illness or Accidental Injury is a Covered Service when provided in a medical office, subject to the Cost Sharing Amounts set forth in your Benefits Summary.

3.25 Preventive and Wellness Health Services

We cover those services that are recognized and defined by QualChoice's Medical Policies as being preventive and/or wellness in nature. Subject to changes QualChoice may make to its Medical Policies, a partial listing of those services QualChoice considers to be preventive and/or wellness health services is included with your Benefits Summary. The most complete list of those services QualChoice considers being preventive and/or wellness health services are available on our website www.qualchoice.com or you may contact our Customer Service department to obtain specific coverage guidelines.

3.26 Professional Services for Complex Surgery

We cover complex surgeries subject to the limitations described below including application of all Cost Sharing Amounts and other limitations as set forth in this Certificate and related Benefits Summary.

The Benefit amount payable for a complex surgery includes payment for related or follow-up care by the surgeon before and after the operation. In other words, the one payment covers the operation and the surgeon's care after the operation. Payment for surgery is subject to the following limitations:

1. When multiple or bilateral surgical procedures are performed in the same operative session, whether through one or more incisions, we will cover the major or first procedure and, in addition, we will cover one-half of the Maximum Allowable Charge of the lesser or subsequent procedure(s).
2. When an incidental procedure, including, but not limited to, incidental appendectomy, treatment of adhesions, excision of previous scar, or puncture of ovarian cyst, is performed through the same incision, we will only pay for the major procedure;
3. When the physician performs an operative procedure in two or more stages, the total payment for the combination of steps or stages making up the entire procedure will be limited to the Maximum Allowable Charge that we would have paid if the physician had not performed it in multiple steps or stages;
4. Not all surgeries require an assistant surgeon; we will pay for one assistant surgeon who is a physician qualified to act as an assistant for the surgical procedure when Medically Necessary;

5. We will cover a standby physician only if that physician is required to assist with certain high-risk deliveries identified by us and only if that physician is in the immediate proximity to the Enrollee during the standby period.

3.27 Prosthetic Services and Prosthetic Devices

Prosthetic services and prosthetic devices (as defined in this Section) are covered as described below.

All "prosthetic devices" and "prosthetic services", including the fitting and/or repair of prosthetic devices, require pre-authorization as described in Section 2.11.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under this Certificate, the device must meet all three (3) of the following requirements:

1. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and
2. The device must be prescribed by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, or (iii) licensed doctor of podiatric medicine; and
3. The device must be provided by a (i) licensed doctor of medicine, (ii) licensed doctor of osteopathy, (iii) licensed doctor of podiatric medicine, (iv) licensed orthotist, or (v) licensed prosthetist.

A prosthetic device includes a breast prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does *not* include a/an (i) artificial eye, (ii) artificial ear, (iii) dental appliance (which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), (iv) cosmetic device such as artificial eyelashes or wigs, (v) device used exclusively for athletic purposes, (vi) artificial facial device, or (vii) any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

QualChoice does not cover replacement of an prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.

3.28 Reconstructive Surgery

We cover services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

1. Restoration must be aimed at restoration of function, not just restoration of appearance;
2. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is *not* covered);
3. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a Child covered under this Certificate.

Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Enrollee;
2. Surgery performed on a child for the correction of a cleft palate or cleft lip, removal of a port-wine stain (**only** on the face), or correction of a congenital abnormality. In order to be covered, such corrective surgery for a congenital defect must be performed when the child is twelve (12) years or younger, unless, in its sole discretion QualChoice determines that due to the complexity of the procedure, such surgery could not be performed prior to the child's twelfth (12^{th}) birthday. Dental care to correct congenital defects is not a covered benefit;
3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery;
4. In connection with a mastectomy eligible for coverage under this Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphademas; or
5. Reduction Mammoplasty that meets our criteria for coverage (which you may request to obtain a copy from us) is a Covered Service subject to Deductible and 50% Coinsurance. Pre-authorization is required.

Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. As further explained in Section 4.1, we do not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services.

3.29 Skilled Nursing Facility and In-patient Rehabilitation Services

Coverage is available for Medically Necessary care in a skilled nursing facility or acute in-patient rehabilitation facility when provided immediately after hospitalization in an acute care general facility for a covered illness or injury. Care will be limited to the number of covered days provided by your Certificate and if Medically Necessary for continued improvement. See your Benefits Summary for details.

3.30 Therapeutic and Rehabilitation Services

Services for outpatient physical, occupational or speech therapy, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a facility. Refer to your Benefits Summary and Section 4 for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that Benefits are available only for services that are expected to result in a significant improvement in the Enrollee's condition within two months of the start of the treatment.

3.31 Transplantation Services

Transplant Benefits are available subject to the general conditions for payment specified in Section 4, and to all other applicable conditions, limitations and exclusions of this Certificate. Consult your Benefits Summary for applicable Cost Sharing Amounts and other limitation amounts.

1. **Pre-Authorization Required:** ***You or an authorized representative must call the number on your QualChoice identification card to obtain pre-authorization before your evaluation for transplant and placement on any transplant list***. Once the evaluation is complete, you must obtain an additional pre-authorization for the transplant procedure. We will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with us, or failure to comply with pre-authorization procedures, may result in non-payment of these services.
2. **Transplant Standards:** We cover transplant procedures under the standards set out by the Certificate as follows:

A. **Transplant Covered Services:** We will cover any facility, medical, surgical, and other service related to the transplant, including blood and blood plasma. **We only cover transplants and transplant related services performed at a transplant center approved by us**.
B. **Facility Care:** We cover all in-patient and outpatient care at a designated transplant center. When we authorize the transplant to occur at an Out-of-Network Facility, we may require Network Providers at a Network Facility to provide some follow-up care.
C. **Organ Procurement:** We will pay for services directly related to organ procurement including tissue typing, surgical extraction and storage and transportation costs of the organ or other human tissue used in a covered transplant procedure. This coverage applies to the donor whose organ has been selected to be used in the transplantation. (If the donor has other insurance, we must receive an explanation of benefits from the donor's health plan indicating coverage or denial for the donation.) Please refer to your Benefits Summary for Cost Sharing Amounts and lifetime maximums.

3. **Bone Marrow Transplantation:** Bone marrow transplantation is only covered for specific indications listed below. This limitation applies to the bone marrow transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Covered diseases are:
   A. Aplastic anemia
   B. Wiscott-Aldrich syndrome
   C. Albers-Schonberg syndrome
   D. Hemoglobinopathy, e.g., Thalassemia major
   E. Myelodysplastic syndromes – primary and acquired
   F. Immunodeficiency syndrome
   G. Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
   H. Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
   I. Neuroblastoma, stage III or IV
   J. Chronic myelogenous blast leukemia in blast crisis or chronic phase
   K. Chronic myelogenous leukemia in the chronic phase
   L. Multiple myeloma
   M. Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse
   N. Chronic Lymphocytic Leukemia
   O. Marrow failure, Fanconi's, red cell aplasia
   P. Amyloidoosis
   Q. Paroxysmal Nocturnal Hemoglobinuria

   This Certificate requires specific donor matches for certain procedures.

4. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions as set forth in this Certificate. Cornea transplantation does not require pre-authorization.

IMPORTANT NOTE REGARDING TRANSPLANTATION SERVICES: It is important that you review and understand the benefit limitations for transplant services described in Section 4.2 of this Certificate.

4. NON-COVERED SERVICES, EXCLUSIONS AND LIMITATIONS

Some services, treatments, medications and supplies are not covered. Others have limitations on coverage. This section describes those exclusions and limitations. One or more of our optional coverage riders may cover some of these items. If you have purchased riders, they will be provided to you in writing. Please refer to your Benefits Summary for additional exclusions and limitations on Covered Services. QualChoice may provide very limited coverage for some services that are otherwise excluded

or limited by this Section 4 strictly for preventive health purposes; where applicable, these limited coverages are identified and described in QualChoice's Preventive Health Benefit Medical Policy.

4.1 Non-Covered Services and Exclusions from Coverage

1. **Abortion:** We do not cover elective abortion. We do not cover medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. We do not cover any services, supplies or treatment provided as a result of such an abortion.
2. **Adoption and Surrogate Parenting:** We will not cover services, supplies, treatment, or other costs relating to the care of the biological mother of an adopted Child. Maternity charges incurred by an Enrollee acting as a surrogate mother are not covered charges. For the purpose of this Certificate, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth. Refer to Section 5.1 for information regarding coverage of adopted children.
3. **After Hours or Weekend Charges:** We will not cover any extra charges related to the time of day or day of the week on which services were rendered.
4. **Against Medical Advice:** We will not cover any services related to an in-patient admission, observation admission, or emergency room visit resulting in the Enrollee's discharge against medical advice. We will not cover any services required for complications resulting from the Enrollee's discharge against medical advice.
5. **Alternative or Complementary Medicine:** We will not cover devices or services relating to alternative systems of medical practice such as the following:
   A. Acupuncture;
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy;
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy; and
   K. Massage Therapy (except as provided for in QualChoice's Medical Policies).
6. **Baby Formula:** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.
7. **Blood and Blood Donation:** We do not pay for any charges associated with blood donations. We do not pay for procurement, or storage, of donated blood. We do not cover umbilical cord blood banking or blood banking for blood or blood products with unscheduled future use. We do cover the charges for administration of blood and blood products. We do cover blood or blood product banking charges for covered procedures planned in the next 180 days.
8. **Blood Typing:** Blood typing or DNA analysis for paternity testing is not covered.
9. **Care Plan Oversight**: Multi-disciplinary team conferences as well as any other kind of team conferences are not covered.
10. **Care Provided By a Relative by Blood or Marriage:** We will not cover care provided by an individual who normally resides in your household. We also will not cover care provided by you or by your parents, siblings, spouses, children, grandparents, aunts, uncles, nieces and nephews or other relatives by blood or marriage.
11. **Care Rendered in Certain Non-Facility Institutions:** We will not pay for care in facilities not licensed as short-term acute care general facility or skilled nursing facilities, for example:
    A. Convalescent homes or similar institutions;
    B. An institution primarily for Custodial Care, rest or domicile;
    C. Residential care or treatment facilities;

D. Health resorts, camps, safe houses, spas, sanitariums, schools, or tuberculosis facility;
E. Infirmaries at camps or schools;
F. Hospitals for treatment of a Mental Health or Substance Use Disorder;
G. Rehabilitation facilities and rehabilitation units in other facilities (except as covered under Section 3.29);
H. Skilled nursing facilities and places primarily for nursing care (except as covered under Section 3.29);
I. Extended care, chronic care, or transitional facilities or facilities (except as covered under Section 3.29); or
J. Other facilities and institutions, which do not meet our criteria for short-term acute care general facility or skilled nursing facilities

12. **Cerebellar Stimulator or Pacemaker:** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.
13. **Charges In Excess Of Calendar Year or Lifetime Maximums:** We will not cover any service, supply or treatment in excess of the Calendar Year annual treatment limits or lifetime maximums as shown on the Benefits Summary.
14. **Charges for Missed/Canceled Appointments:** We will not pay for charges resulting from the Enrollee's failure to keep scheduled appointments.
15. **Chelation Therapy:** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.
16. **Chemical Ecology:** Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
17. **Chiropractic Care:** Chiropractic care services are not covered.
18. **Complications:** We will not cover medical or surgical complications resulting from a non-Covered Service. We will not cover medical or surgical complications as a direct or closely related result of the Enrollee's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.
19. **Contraceptive Devices or Supplies:** Contraceptive devices or supplies available over-the-counter (without a prescription) are not covered.
20. **Convenience Items or Services:** We will not cover items or services utilized primarily for your convenience or the convenience of a family member, caregiver or provider. Such items include, but are not limited to, a cot, hot water bottle, telephone, television, television rental charges, whirlpool bath, automobile/van conversion, wheel chair ramp, and home modifications.
21. **Cosmetic or Reconstructive Services**: Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. We will not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services. Procedures or services that change or improve appearance without improving physiological function are also not covered. Procedures or services that correct a physical developmental defect present at the time of birth without improving or restoring physiologic function are considered cosmetic procedures. The fact that an Enrollee may suffer psychological consequences as a result of an injury, sickness or developmental defect present at the time of birth, does not make the service Medically Necessary.
22. **Custodial Care:** We do not cover Custodial Care. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial Care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding, or range of motion exercises. Non-covered Custodial Care may be rendered in a facility, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.

23. **Dental Care:** This Certificate does not provide Benefits for dental care. Except as otherwise stated in this Certificate, we do not cover:
    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess;
    G. Treatment of dentigerous cysts;
    H. Removal of soft tissue supporting or surrounding teeth;
    I. Orthodontia (including braces);
    J. False teeth;
    K. Orthognathic surgery; or
    L. Any other dental services you may receive, except as specifically set out in your Benefits Summary.
24. **Dental Implants:** Dental implants of titanium osseointegrated fixtures or of any other material are not covered.
25. **Dermatomal Somatosensory Evoked Potentials:** Dermatomal somatosensory evoked potential testing is not covered.
26. **Developmental Delay:** Services or supplies provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit, and motor dysfunctions are not covered. Except for an autism screening occurring one time between the ages of 1 and 4, this includes an exclusion for developmental delay associated with autism spectrum disorder.
27. **Dietary and Nutritional Services:** Unless dietary supplies are the sole source of nutrition for the Enrollee (see Section 3.21 - Medical Foods), any services or supplies provided for dietary or nutritional services, including, but not limited to, medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a physician or acquired over-the-counter, are not a covered.
28. **Domestic Partners:** We do not provide coverage for domestic partners of the same sex or opposite sex.
29. **Dynamic Orthotic Cranioplasty:** Dynamic orthotic cranioplasty is not covered.
30. **Electron Beam Computed Tomography:** Electron beam computed tomography is not covered.
31. **Electronic Consultations:** We do not cover charges for a healthcare provider's consultation by telephone, email, or other electronic communications with you or another healthcare provider.
32. **Electrotherapy and Electromagnetic Stimulators:** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, are not covered. However, subject to all terms, conditions, exclusion and limitations as set forth in this Certificate; coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.
33. **Enhanced External Counterpulsation:** Enhanced external counterpulsation (EECP) is not covered. However, subject to all terms, conditions, exclusion and limitations in this Certificate, and at the sole determination of QualChoice, coverage may be provided for enhanced external counterpulsation for the treatment of Enrollees with coronary artery disease documented by coronary artery catheterization. Our Medical Policy regarding enhanced external counterpulsation is available on our website www.qualchoice.com or you may contact our customer service department to obtain specific coverage guidelines.
34. **Environmental Intervention:** Services or supplies used in adjusting an Enrollee's home, place of employment or other environment so that it meets the Enrollee's physical or psychological condition are not covered.
35. **Excessive Use:** Excessive use of medications is not covered. For purposes of this exclusion, each Enrollee agrees that QualChoice shall be entitled to deny coverage of medications under this Certificate, on grounds of excessive use when it is the determination

of our medical director that: (1) an Enrollee has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia, or by the QualChoice Pharmacy & Therapeutics Committee; or (2) an Enrollee has obtained or attempted to obtain the same medication from more than one physician for the same or overlapping periods of time; or (3) the pattern of prescription medication purchases, changes of physicians or pharmacy, or other information indicates an Enrollee has obtained or sought to obtain excessive quantities of medications. Each Enrollee hereby authorizes QualChoice to communicate with any physician, health care provider, or pharmacy for the purpose of reviewing and discussing the Enrollee's prescription history, use, or activity to evaluate for excessive use.

36. **Exercise Programs:** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers, and home exercise equipment, even if recommended or prescribed by a physician.
37. **Experimental or Investigational Procedures and Related Equipment and Supplies:** We will not cover any procedure or service we consider to be experimental or investigational. We also will not pay for equipment or supplies related to such procedures. We base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we consider it for coverage. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group.
38. **Extracorporeal Shock Wave Therapy:** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including, but not limited to, plantar fasciitis or tennis elbow, is not covered.
39. **First Aid Supplies:** We will not cover over-the-counter first aid supplies.
40. **Foot Care:** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, non-surgical care of bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations of this Certificate, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.
41. **Foot Orthotics:** Foot orthotics that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.
42. **Fraud or Misrepresentation:** Health interventions or health services, including, but not limited to, medications obtained by unauthorized or fraudulent use of an Enrollee's QualChoice identification card or by material misrepresentation as part of your enrollment process or at other times, are not covered.
43. **Free Care:** We will not cover any care if there was no charge for the care. This applies even if you and/or the provider did not think there would be insurance when the provider chose not to charge for the care provided.
44. **Gastric Electrical Stimulators:** Gastric electrical stimulators or electrogastrography are not covered.
45. **Government Programs:** We will not pay for Covered Services to the extent Benefits for such services are payable under Medicare or any other federal, state or local government program.
46. **Group Therapy:** Group therapy or group counseling at any time in any setting by any provider is not covered.

47. **Hair Loss or Growth:** Wigs, hair transplants, or any medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.
48. **Hearing or Talking Aids:** Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered. Cochlear implants are the only exception to this exclusion as specified in Section 4.2(4).
49. **Heat Bandage:** Treatment of a wound with a warm-up active wound therapy device or a non-contact radiant heat bandage is not covered.
50. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or nonmyeloablative Allogeneic Stem Cell Transplantation:** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants, and Nonmyeloalative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in Section 3.31.
51. **Home Uterine Activity Monitor:** Home uterine activity monitors or their use is not covered.
52. **Illegal Acts:** Except as required by law, we will not cover health care services resulting from participation in a felony, riot, insurrection, or other illegal act, whether or not convicted.
53. **Illegal Uses:** Medications, drugs, or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered. Complications or accidental injuries from illegal drug use or while driving under the influence of alcohol determined to be in excess of legal limits are not covered.
54. **Impotence or Sexual Dysfunction:** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury, or prostate surgery.
55. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered.
56. **Infertility Treatment:** We will cover a basic diagnostic work-up to make an initial diagnosis of infertility. We will not cover any medications, procedures, or other services for treatment of infertility. It does not matter whether the infertility service is diagnostic or therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:
    A. Reversal of sterilization;
    B. Pre-implantation testing;
    C. Surrogate pregnancies;
    D. Medical treatment of infertility;
    E. Surgical treatment of infertility; and
    F. In vitro fertilization

    Note: We will not pay for surgery that is done primarily for infertility treatment even when other diseases or conditions that may be the underlying cause of the infertility are detected or treated during such surgery.
57. **Inotropic Agents for Congestive Heart Failure:** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, where the Enrollee is on a cardiac transplant list at a facility where there is an ongoing cardiac transplantation program, the Certificate will cover infusion of inotropic agents.
58. **Instructional Programs:** We will not pay for instructional or educational testing, programs, seminars, or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in Section 3.8.
59. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders:** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.

60. **Learning Disabilities:** Services or supplies provided for learning disabilities, for example, reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties, are not covered.
61. **Lost Medications:** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. is not covered.
62. **Magnetic Innervation Therapy:** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.
63. **Maintenance Therapy:** We will not cover maintenance therapy for physical therapy, occupational therapy, or speech therapy.
64. **Mammoplasty:** Except as provided in Section 3.28, we do not cover mammoplasty for reasons of augmentation or asymmetry of the breasts. We do not cover removal of breast implants placed or removed for cosmetic purposes.
65. **Mandated or Court Ordered Care:** We will not cover any medical, psychological, or psychiatric care which is the result of a court order or otherwise mandated by a third party such as, but not limited to, an employer, licensing board, recreation council, or school.
66. **Marriage and Relationship Counseling:** Marriage and relationship counseling services are not covered.
67. **Medical Reports:** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms or the preparation or copying of medical records.
68. **Medical/Surgical Services or Supplies for Control of Obesity or Morbid Obesity:** We will not cover any surgery, medical services, or supplies intended for control of either obesity or morbid obesity even if the obesity or morbid obesity aggravates another condition or illness. This would include services such as dietary control, medications, counseling, weight maintenance programs, gastric stapling, gastric bypass, or any other service intended to control obesity. We do not cover surgical or medical procedures to treat the complications or consequences of weight loss, such as abdominoplasty or panniculectomy.
69. **Medication Therapy Management Services:** Medication therapy management services by a pharmacist, including, but not limited to, a review of an Enrollee's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.
70. **Mental Health or Substance Use Disorder:** Services of any kind or nature for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse are not covered. Services that are excluded include, but are not limited to:
    A. Testing, evaluation, assessment and/or treatment of every diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
    B. Hypnotherapy;
    C. Treatment of behavior or conduct disorders, oppositional disorders, or neuroeducational testing;
    D. Hospitalization for testing, evaluation, assessment and/or treatment of mental health or psychiatric conditions, behavior, emotional, or conduct disorders, or substance or alcohol abuse;
    E. Evaluation of psychosocial factors potentially impacting physical health problems and treatments, including health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems;
    F. Services for treatment of eating disorders are not covered; this exclusion includes treatment for anorexia, bulimia and other eating disorders; and
    G. Family counseling in conjunction with an Enrollee's individual crisis therapy.
71. **Non-Compliance with Recommended Treatment:** We will not cover services provided as the result of an Enrollee's refusal to comply with a physician's or other provider's

recommendations or orders, or failure to cooperate with a prescribed plan of treatment or recovery.

72. **Nutritional Counseling or Nutritional Supplements:** Benefits are not available for dietary control counseling or weight maintenance programs. For Enrollees with diabetes, see Section 3.8.
73. **Orthognathic Surgery:** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. For coverage of Oral Surgery or Reconstructive Surgery, see Section 3.
74. **Orthoptic or Pleoptic Therapy:** Orthoptic or pleoptic therapy is not covered.
75. **Over-the-Counter Medications:** Medications (except insulin) which do not by law require a prescription from a physician are not covered.
76. **Pain Pump, Disposable:** Disposable pain pumps following surgery are not covered.
77. **Parkinson's Disease, Treatment with Fetal Mesencephalic Transplantation:** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.
78. **Percutaneous diskectomy:** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.
79. **Percutaneous Kyphoplasty:** Percutaneous kyphoplasty is not covered.
80. **Percutaneous Sacroplasty:** Percutaneous sacroplasty is not covered.
81. **Performance Enhancement:** We will not cover medical, surgical, or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic, or recreational performance, including, but not limited to, work hardening programs, back schools, programs of general physical conditioning, athletic trainers, and special or specially modified surgical procedures designed to enhance performance above normal.
82. **Peripheral Nerve Stimulators:** Peripheral nerve stimulators are not covered.
83. **Peripheral Vascular Disease Rehabilitation Therapy:** Peripheral vascular disease rehabilitation therapy is not covered.
84. **Pre-existing Conditions:** Benefits for the treatment of a Pre-existing Condition are excluded until you have had continuous coverage under your previous group policy and this Certificate for 12 months. This exclusion does not apply to an Enrollee under the age of 19.
85. **Pre-Implantation Genetic Diagnosis:** We do not cover pre-implantation genetic diagnosis or treatment.
86. **Premarital Laboratory Work:** We will not cover premarital laboratory work required by any state or local law.
87. **Prescription Drugs:** We do not cover medications prescribed for an Enrollee for use on an outpatient basis, that is, medications not dispensed or administered when an Enrollee is in a hospital, skilled nursing facility or other healthcare facility.
88. **Private Duty Nurses:** We will not cover private duty nurses.
89. **Private Room:** We do not cover a private facility room. We will pay the most common charge for semi-private accommodations. If you are charged for a private room, you must pay the difference between the charges for a private room and our payment.
90. **Prolotherapy:** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
91. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions:** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
92. **Required Examinations or Services:** We will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:
    A. Obtaining employment;
    B. Maintaining employment;
    C. Obtaining insurance;
    D. Obtaining professional or other licenses;
    E. Engaging in travel;
    F. Athletic or recreational activities; or

G. Attending a school, camp, or other program.

93. **Research Studies:** We will not cover any service provided in connection with research studies or clinical trials.
94. **Rest Cures:** Services or supplies for rest cures are not covered.
95. **Reversal of Sterilization:** We will not cover any procedures or related care to reverse previous sterilization.
96. **Second Surgical Opinion and Consultation with Specialist:** We will not cover a second surgical opinion and a consultation from the same physician or from two physicians who are in practice together.
97. **Self-inflicted Injuries:** Services for intentional self-inflicted injuries, including drug overdose, are not covered, except when it is determined the act causing the injury resulted from a medical condition (physical or mental) meeting the definition of a Mental Health or Substance Abuse Disorder.
98. **Sensory Stimulation of Coma Patients:** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
99. **Services Not Specified as Covered Services:** We will not cover any services not specifically described in Section 3 of this Certificate as being a Covered Service.
100. **Services Received Outside the United States:** Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of QualChoice.
101. **Sex-Change Treatment:** We will not cover surgical procedures or related care to alter your sex from one gender to the other.
102. **Sexual and Gender Identity Disorders**: Any services related to the treatment of sexual and gender identity disorders are not covered.
103. **Short Stature Syndrome:** Any services related to the treatment of short stature syndrome are not covered, except when short stature is caused by laboratory documented growth hormone deficiency.
104. **Sleep Apnea, Portable Studies:** Studies for the diagnosis, assessment, or management of obstructive sleep apnea, not continuously attended by a qualified technician, are not covered.
105. **Smoking or Tobacco Cessation or Caffeine Addiction:** Unless a Smoking Cessation Rider is included with this Certificate, treatment of caffeine, smoking, or nicotine addiction, smoking cessation prescription medication products, including, but not limited to, nicotine gum and nicotine patches, are not covered.
106. **Snoring:** Devices, procedures, or supplies to treat snoring are not covered.
107. **Sperm and Embryo Preservation and Donation:** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.
108. **Sterilization, Voluntary Hysterectomy:** We will not cover charges related to hysterectomy for the primary purpose of voluntary sterilization. We will not cover charges related to implantation of the Essure device or other similar devices identified at our sole discretion. You may contact us to obtain a listing of such devices.
109. **Temporomandibular Joint Syndrome (TMJ):** Unless a TMJ Rider is included with this Certificate, we will not cover charges related to treatment or diagnosis of TMJ, including, but not limited to, medical, surgical, and dental treatment, physical therapy, joint splints, adjustments, medications, as well as any orthotic treatment. All other procedures involving the teeth or areas surrounding the teeth are not covered, including, but not limited to, the shortening of the mandible or maxillae or the correction of malocclusion.
110. **Thermography:** Thermography, which is the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
111. **Third Party Liability Exclusion:** We will not pay any Benefits to an Enrollee to the extent the Enrollee has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or facility or other health care charges as the result of the negligence or intentional act of a third party. If an Enrollee makes a Claim for Benefits under this Certificate prior to receiving payment from a third party, or its insurer, the Enrollee (or legal representative for a minor or incompetent) agrees to repay us from any amount of money

received by the Enrollee from the third party, or its insurer. Please refer to Section 8 and Section 10.8 for further information concerning repayment of Benefits.

112. **Thoracic Electrical Bioimpedance:** Thoracic electrical bioimpedance is not covered.
113. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae:** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
114. **Trans-telephonic Home Spirometry:** Trans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.
115. **Travel and Transportation Expenses:** We will not cover travel and transportation expenses, even if prescribed by a physician, except for ground or air emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department. Refer to your Benefits Summary for limitations.
116. **Travel, School, Recreation, or Work Related Immunizations:** Except to the extent coverage is specifically provided in this Certificate as a preventive health benefit, we will not cover immunizations to fulfill requirements for international travel, school, recreation, or for work.
117. **Unlicensed Provider:** Coverage is not provided for treatment, procedures or services provided by any person or entity, including but not limited to physicians, who is required to be licensed to perform the treatment, procedure or services, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of QualChoice, include within its scope the treatment, procedure or service provided.
118. **Vision:** Except as set forth in the Benefits Summary, we will not cover routine eye, services or tests, eyeglasses, contact lenses, and other vision care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes.
119. **Vision Correction:** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglass and contact lenses (except the initial acquisition of one pair within the twelve months following cataract surgery up to $200 for frames and lenses), are not covered.
120. **Vitamins or Supplements:** Vitamins or nutrient supplements not available over the counter are not covered. However, subject to all terms, conditions, exclusions and limitations of this Certificate, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism as described in Section 3.21 – Medical Foods.
121. **War or Act of War:** We will not cover any services relating to any injury or sickness resulting from war or any act of war (declared or undeclared), or in the armed forces of any country if any government plan covers the injury or sickness.
122. **Weight Control:** Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
123. **Whole Body Computed Tomography:** Whole body computed tomography is not covered.
124. **Workers' Compensation:** We will not cover any care or supplies for any injury, condition, or disease arising from your employment. We will not make any payments even if you do not claim the benefits you are entitled to receive under the Workers' Compensation Law.
125. **Wound Treatment:** Blood derived growth factors are not covered.

4.2 Limitations to Benefits

Coverage is available for medical services or care as specified in this Section 4.2 subject to the General Conditions for Payment specified in Section 2.9, Pre-Authorization of Services described in Section 2.11, and to all other applicable conditions, limitations and exclusions of this Certificate.

1. **Ambulance:** Transportation by ambulance of any kind is limited to a maximum annual benefit amount, and is subject to review for Medical Necessity. Consult your Benefits Summary for benefit limitations.
2. **Auditory Brain Stem Implant.** One auditory brain stem implant per lifetime is covered for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone removal of bilateral acoustic tumors.
3. **Biofeedback:** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the QualChoice Medical Policies.
4. **Cochlear Implants:** Coverage for cochlear implants is subject to a maximum lifetime benefit of $20,000 per Enrollee. Coverage is limited to one cochlear implant device, the surgical procedure, and one speech processor. Reimplantation of the same device is not covered. Pre-authorization is required.
5. **Circumstances Beyond Our Control:** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of facility or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.
6. **Durable Medical Equipment (DME):** Benefits for DME is limited to an annual dollar maximum and must be obtained from a Network Provider. Out-of Network DME is not covered. Please refer to your Benefits Summary for this annual limit.
7. **Genetic Counseling and Testing:** Genetic testing is generally not covered. Genetic testing is often done on blood or tissue samples sent by your physician to a laboratory. *For genetic counseling or testing to be covered, it requires pre-authorization.* Pre-authorization will only be given in accordance with QualChoice's Medical Policies which require the results of the genetic testing to affect choice of treatment or the outcome of treatment. We will not cover genetic counseling or testing to determine the likelihood of:
    A. Developing a disease or condition; or
    B. Disease or the presence of a disease in a relative; or
    C. Passing an inheritable disease, for example, cystic fibrosis, or congenital abnormality to an offspring.

    However, subject to all terms, conditions, exclusions and limitations set out in this Certificate, genetic testing of the products of an amniocentesis to determine the presence of a disease or congenital anomaly in the fetus or genetic testing of an Enrollee's tissue to determine if the Enrollee has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered if the test meets QualChoice's Medical Necessity criteria. Any approved genetic testing must be preceded by genetic counseling.
8. **Home Health Care:** Home health visits are limited to a maximum number of visits per Enrollee per Contract Year. The home health care visit limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
9. **Hospice Services:** Hospice services are limited to a maximum number of days of coverage per Enrollee. The hospice services day limitation and the Cost Sharing Amounts are specified in your Benefits Summary. Pre-authorization is required.
10. **In Vitro Chemoresistance and Chemosensitivity Assays:** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to QualChoice's Medical Policies.
11. **Insulin Pump for Diabetes Mellitus:** We will cover insulin pumps to a Maximum Allowable Charge of $5,500. Insulin pump supplies are covered under your medical benefit and are not subject to this limitation. Pre-authorization is required.

12. **Lifetime Maximum:** Consult your Benefits Summary and this Certificate for various lifetime maximum Benefits per Enrollee.
13. **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Network Physicians and Network Facilities will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.
14. **Medical Supplies:** Coverage of medical supplies is limited to a 31-day supply per month.
15. **Newborn Care:** We will cover Newborn Children of the Certificate Holder or spouse from the date of birth provided the Certificate Holder enrolls the newborn within 90 days after the date of birth.
16. **Outpatient Rehabilitation Services:** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation, and cardiac rehabilitation services are limited to a maximum number of visits per Enrollee per Contract Year as reflected in your Benefits Summary. Any outpatient rehabilitation services obtained from an Out-of-Network Provider will not be covered as set out in your Benefits Summary.
17. **Prosthetic and Orthotic Devices and Services.** QualChoice does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, QualChoice will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to Co-payments, Deductibles, and Coinsurance as set out in your Benefits Summary.
18. **Refusal to Accept Treatment:** You may refuse to accept procedures or treatment recommended by Network Physicians for personal reasons. In such case, neither we nor any Network Physician or Provider shall have any further responsibility to provide care for the condition under treatment, unless you later recant the refusal and agree to follow the recommended treatment or procedure.
19. **Shoes and Shoe Inserts:** Custom molded and fitted shoes and shoe inserts are not covered except for an Enrollee with diabetes. Coverage for an Enrollee with diabetes for custom molded and fitted shoes and shoe inserts is subject to the following limitations:
    A. Two (2) pairs of custom molded and fitted shoes per year if the Enrollee is under 18 years of age and one (1) pair of custom molded and fitted shoes for an Enrollee 18 years of age or older; and
    B. Two (2) pairs of custom molded shoe inserts per year.
20. **Transplant Services:** Transplant services are subject to the following benefit maximums and limitations:
    A. Coverage for procurement and testing (per transplant) is limited to the amount reflected in your Benefits Summary;
    B. Lifetime maximum organ transplant coverage is limited to the amount reflected in your Benefits Summary ;
    C. We will not cover the transportation and/or lodging costs of the transplant recipient, transplant donor, or individuals traveling with either the donor or the recipient. We will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs;
    D. Coverage is limited to no more than the number of transplants per Enrollee per lifetime as reflected in your Benefits Summary. We cover re-transplantation, but a re-transplant is considered a transplant and counts toward the transplant limit;
    E. Expenses for drugs related to avoidance of rejection of a transplanted organ are subject to the lifetime transplant maximum as reflected in your Benefits Summary;
    F. Solid organ transplants of any kind are not covered for an Enrollee with a malignancy of any kind that is presently active, in partial remission, or in complete remission less than two (2) years. A solid organ transplant of any kind is not covered for an Enrollee that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small

or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis; and

G. **Transplants that are not pre-authorized by QualChoice Care Management Department are not covered.**

5. ELIGIBILITY CRITERIA

5.1 Who is Eligible for Coverage

Only you and your dependents who were covered under your original employer group policy on the date of termination of coverage under that employer group policy are eligible for coverage under this Certificate. You must list yourself and any of your eligible dependents you are electing to cover on the Enrollment Application to be eligible for coverage. If you do not list them on the Enrollment Application, they will not be eligible for coverage under this Certificate. You and your dependents must meet all eligibility requirements in this Certificate. The following members of your family may be eligible as dependents as long as they were covered under your original employer group policy on the date of termination of coverage under that employer group policy:

1. Your spouse, unless you are divorced or have annulled your marriage. Domestic partners are not eligible for coverage as a dependent under this Certificate.
2. Your Child until s/he becomes twenty-six (26) years of age. However, if your prior employer group policy is a grandfathered plan, your Child nineteen (19) years of age and older but who has not attained the age of twenty-six (26) years is eligible only if s/he is not otherwise eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.
3. Your incapacitated Child may be an eligible dependent. The incapacitated Child must be twenty-six (26) years of age or older and totally disabled due to continuous developmental or physical incapacity. The incapacitated Child must be primarily dependent on you for financial support and you must declare the incapacitated Child as a dependent on your federal income tax returns. The disability leading to mental or physical incapacity must have occurred before the Child reached age twenty-six (26) and while covered under this Certificate or other group medical insurance coverage. The Social Security Administration or a physician must medically certify the disability. In addition to this medical certification, we have the unilateral right to determine whether a Child is, and continues to qualify as an incapacitated Child. At any time, we may request a declaration of disability (or like document) supporting such dependent's incapacity and dependency. You must notify us if the incapacity or dependency is removed or terminated. Newly eligible Enrollees may enroll an incapacitated Child provided the disability commenced before the limiting age and a health benefit plan continuously covered the Child as your dependent since before the limiting age. Our determination of eligibility shall be conclusive.
4. Coverage for a Child whom you have adopted or for whom you have filed a petition for adoption shall begin on the date of the adoption or the date of the filing of the petition for adoption. You must submit an Enrollment Application to us within 60 days after the adoption or the filing of the petition. Coverage will begin subject to payment of all applicable premiums. The coverage shall begin from the moment of birth if the petition for adoption or adoption occurred and you submit the application for coverage to us within 60 days of the birth of the Child. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

Your coverage begins upon the effective date of this Certificate which is the day following your termination of your coverage under the group Certificate. You should contact our Customer Service Department for information concerning your eligibility requirements and effective date. You will not be eligible to enroll if you do not meet the eligibility rules of this Certificate.

Neither you nor your dependent will be eligible to enroll if:

1. You have had previous coverage with us terminated for causes described in Section 5.4(5) of this Certificate.
2. Such person is covered for similar benefits by another hospital, surgical, medical, or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program.
3. Such person is eligible for similar benefits (whether or not covered therefor) under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis.
4. Such benefits are provided for or available to such person, pursuant to or in accordance with the requirements of any state or federal law.
5. The benefits provided under subparagraph (2) above for such person, or benefits provided or available under the sources referred to in subparagraphs (3) and (4) above for such person, together with the benefits provided by this Certificate, would result in over-insurance according to our standards as filed with Arkansas Insurance Department, if any.
6. If such person is eligible for Medicare.

Coverage for newborn or adopted children in your family begins on the date they meet the eligibility requirements of this Certificate. Coverage for your newborn Child is effective as of the date of birth if you submit an Enrollment Application to us within 90 days of the date of birth of the Child or before the next premium due date, whichever is later. Coverage for your adopted Child is effective as of the date of the adoption if you submit an Enrollment Application to us within 90 days of the date of the adoption of the Child or before the next premium due date, whichever is later.

Coverage, subject to all other terms, conditions, exclusions and limitations of this Certificate, will be extended to an eligible Enrollee who is inpatient in a facility on the effective date of this Certificate. However, consistent with applicable law, if such eligible Enrollee is inpatient in a facility on the effective date of this Certificate and immediately prior to such effective date was covered by a group health plan that provides coverage for facility or medical services or expenses, coverage for benefits under that other group health plan will continue and it will be primarily responsible for those services and expenses associated with that facility admission. As the primary plan, that other group health plan will be responsible for those services and expenses until the end of that facility admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

If your Covered Dependent gives birth, the newborn grandchild is not eligible for coverage. If you, as the Child's grandparent, adopt or become the legal guardian of the Child, we will cover the Child from the effective date of the adoption or the legal guardianship.

5.2 Termination of Coverage

Your coverage under this Certificate will terminate in certain circumstances. We describe these circumstances below.

1. **Default in Payment of Premiums:** Premiums are due on or before the first day of each month of Coverage under this Certificate. Failure to remit premium payments to us in accordance with these terms may result in the suspension of Benefits for you and your Covered Dependents. In the event you do not respond timely to written and verbal demands for payment by us, coverage under this Certificate will be terminated retroactive to the last day of the month for which premium payment was received.
2. **Certificate Holder's Death:** Coverage for Covered Dependents under this Certificate will automatically terminate on the date of the Certificate Holder's death.
3. **Becoming Eligible for Medicare:** When an Enrollee becomes eligible for Medicare, that Enrollee is no longer eligible for coverage under this Policy and should notify us immediately.
4. **Termination of Your Marriage:** If you divorce, legally separate, or annul your marriage, the coverage of the Certificate Holder's spouse will automatically **terminate on the date of the**

divorce, legal separation, or annulment. A court order requiring the Certificate Holder to provide coverage for the former spouse does not change the termination of coverage.

5. **Termination of Coverage of A Dependent Child:** The coverage of a Child under this Certificate will terminate automatically on the earliest of the following dates on which the Child:
    A. No longer meets the limiting age eligibility requirements;
    B. For a Child incapable of self-support (an incapacitated Child), on the date the Child becomes capable of self-support; termination of coverage based upon age limitation(s) does not apply to a Child who qualifies as an incapacitated Child.
6. **Our Option to Terminate This Certificate:** We may terminate this Certificate for any of the following reasons:
    A. An Enrollee's intentional misrepresentation of material fact or fraud committed by the Enrollee in connection with any Claim for Benefits filed under this Certificate;
    B. Upon 30 days advance written notice to an Enrollee if he or she persistently fails to cooperate in good faith with the administration of coverage under this Certificate or persistently refuses to comply with treatment plans prescribed by a physician and approved by us;
    C. An Enrollee's coverage for failure to pay any applicable Cost Sharing Amount required under this Certificate upon 30 days advance written notice to such Enrollee unless default in payment is cured within such 30-day period;
    D. Upon 30 days advance written notice if an unauthorized person is allowed to use the Enrollee's QualChoice identification card or if the Enrollee otherwise cooperates in the unauthorized use of the Enrollee's identification card or Benefits;
    E. Each Enrollee represents all statements made in his or her application for membership, and any applications for membership of dependents, are true to the best of his or her knowledge and belief. If an Enrollee performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact, we may void his or her enrollment under this Certificate and the enrollment of his or her covered spouse and dependents. No statement made, for obtaining coverage, will void coverage unless the statement is written in the application and you, the Certificate Holder, signs it;
    F. Failure of an Enrollee to provide information necessary for QualChoice to comply with applicable law, including, but not limited to, the Enrollee's social security number or other government issued identification number;
    G. An Enrollee becomes eligible to enroll in a group health plan or government run health plan and all pre-existing conditions are covered under such group health plan or government run health plan; or
    H. Failure to respond to a request for Recovery of Overpayment in accordance with the provisions of Section 10.8.

    QualChoice will notify the affected Enrollee of a decision to terminate the Enrollee's coverage pursuant to the requirements of applicable law. If QualChoice terminates the coverage of an Enrollee, QualChoice shall have no further liability under this Certificate.
7. **Enrollees on Military Leave:** Enrollees (or an Enrollee's Covered Dependent) called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). These rights apply to covered Enrollees and their Covered Dependents immediately before leaving for military service. The following applies to this election:
    A. The maximum period of coverage of a person under such an election shall be the lesser of:
        1. The 24 month period beginning on the date on which the person's absence begins; or
        2. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

B. A person who elects to continue health plan coverage must pay up to 102% of the full contribution, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
C. An exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed services.

8. **Hospital Confinement at Time of Termination**: If an Enrollee is facility confined on the date coverage under this Certificate terminates, coverage for such hospitalization will be determined according to the following criteria:
   A. If the Enrollee replaces this Certificate with other coverage, coverage for the Enrollee will continue until facility discharge or Benefits under this Certificate are exhausted, whichever occurs first;
   B. If the Enrollee **does not** replace this Certificate with other coverage, coverage for the Enrollee will cease on the effective date of termination; or
   C. If termination is a result of rescission of coverage by QualChoice, coverage ends on the effective date of such rescission.

   If the hospitalized Enrollee is the Certificate Holder, coverage for any Covered Dependents of this Enrollee ends on the effective date of termination.

6. COORDINATION OF BENEFITS

You and your family members may have coverage under more than one health plan. This Certificate contains a Coordination of Benefits (COB) provision. This is to eliminate duplication of payment for services. COB will apply for drugs covered under the medical benefit. We do not coordinate against the following kinds of coverage: hospital indemnity coverage or other fixed indemnity coverage, accident only coverage, specified disease or specified accident coverage, limited benefit health coverage, as defined by state law, school accident type coverage, benefits for non-medical components of long-term care policies, Medicare supplement policies, Medicaid policies, or coverage under other federal governmental plans, unless permitted by law.

6.1 How COB Works

The order of benefit determination rules govern the order in which each health plan will pay a claim for benefits. The health plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another health plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all health plans do not exceed 100% of the COB Allowable Expense (described in Section 6.4 below).

6.2 Rules to Determine Primary and Secondary Plans

The following rules will determine primary and secondary plan coverage:

1. If a health plan does not have a COB provision, that plan is primary.
2. The health plan covering the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is primary, and the health plan that covers the person as a dependent is secondary.
3. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one health plan the order of benefits is determined as follows:

   A. For a child whose parents are married or are living together, whether or not they have ever been married:

      (1) The health plan of the parent whose birthday falls earlier in the calendar year is primary; or

      (2) If both parents have the same birthday, the health plan that has covered the parent the longest is primary.

   B. For a child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) The plan of the parent who a court has established as being responsible for the child's health care expenses or health care coverage is primary (we must be informed of this requirement and documentation may be required);

(2) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage , the provisions of Subparagraph A above determines the order of benefits;

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the child, the provisions of Subparagraph A above determine the order of benefits; or

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(a) Plan of the custodial parent;

(b) Plan of the custodial parent's new spouse (if remarried);

(c) Plan of the non-custodial parent; and then

(d) Plan of the new spouse of the non-custodial parent (if remarried).

C. For a dependent child covered under more than one health plan of individuals who are the parents of the child, the provisions of Subparagraph A or B above determine the order of benefits as if those individuals were the parents of the child.

4. The health plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is primary. The health plan covering that same person as a retired or laid-off employee is secondary. The same rule applies to a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. Note that this rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

5. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another health plan, the health plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is primary and the COBRA or state or other federal continuation coverage is secondary. If the other health plan does not have this rule, and as a result, the health plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in Paragraph 6.2(2) above can determine the order of benefits.

7. The health plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is primary and the health plan that covered the person the shorter period of time is secondary.

8. If the preceding rules do not determine the order of benefits, the COB Allowable Expense shall be shared equally between the health plans. In addition, this Certificate will not pay more than it would have paid had it been primary.

6.3 Allowable Expense

For the purposes of this Section 6, "Allowable Expense" is a health care expense (including Deductible, Coinsurance or Co-payments) covered in full or in part by any health care plan covering the Enrollee. This means an expense or service not covered by any plan covering the Enrollee is not an Allowable Expense. Also, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Enrollee is not an Allowable Expense.

If two (2) or more plans cover you and compute their benefit payments based on that plan's maximum allowable payment, any amount in excess of the Allowable Expense of the primary payor for a specified benefit is not an Allowable Expense.

If two (2) or more plans cover you and provide benefits or services based on negotiated fees, any amount in excess of the negotiated fees of the primary payor is not an Allowable Expense.

If you are covered under multiple plans and the Allowable Expense is determined by more than one method, the primary plan's payment arrangement shall be the Allowable Expense for all plans.

6.4 Reduction of Benefits

When this Certificate is secondary, we will reduce our benefits so that the total benefits paid or provided by all plans are not more than one hundred percent (100%) of the total Allowable Expense of the primary plan.

A. In determining the amount to be paid for any claim, QualChoice will calculate the Benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense that is unpaid by the primary plan. QualChoice will then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total Benefits paid or provided by all health plans for the claim do not exceed the total Allowable Expense of the primary plan for that claim.
B. QualChoice will credit to Enrollee's Deductible any amounts it would have credited to the Deductible in the absence of other health care coverage.
C. If an Enrollee is enrolled in two or more closed panel plans (that is, a plan that provides benefits primarily through a panel of contracted health care providers and excludes coverage for services provided by other health care providers) and if, for any reason, including the provision of service by an Out-of Network Provider, benefits are not payable by one closed panel plan, COB shall not apply between that closed panel plan and other closed panel plans.

6.5 Enforcement of Provisions

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the Certificate and other health plans. For the purposes of COB administration, QualChoice will get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the Certificate and other health plans covering the person claiming benefits. QualChoice is not required to tell, or get the consent of, any person, including the Enrollee, to do this. You must give QualChoice any facts we needs to apply those rules and determine Benefits payable. If you fail to provide this information, we may delay Benefit payments.

6.6 Facility of Payment

A payment made under another health plan may include an amount that should have been paid under this Certificate. If it does, QualChoice may pay that amount to the other plan that made that payment. That amount will then be treated as though it were a benefit paid by QualChoice under this Certificate. QualChoice will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6.7 Right of Recovery

If we pay more for Covered Services than this provision allows, we have the right to recover the excess payment. You agree to do whatever is necessary to secure our right to recover excess payments.

6.8 Hospitalization When Coverage Begins

Consistent with applicable law, if an eligible Enrollee is inpatient in a hospital on the effective date of this Certificate and immediately prior to such effective date was covered by a group health plan that provides coverage for hospital or medical services or expenses, coverage for benefits under that other policy, contract, or certificate will continue and it will be the primary plan for those services and expenses associated with that hospital admission. As the primary plan, that group health plan will be responsible for those services and expenses until the end of that hospital admission or until the expiration of any applicable extension of benefits provided under such group health plan, whichever occurs first.

7. Complaints and Appeals

We have authority and full discretion to determine all questions, problems or disputes, arising in connection with Benefits, including but not limited to eligibility, interpretation of Certificate language, and findings of fact about such questions. Our actions, determinations and interpretations with respect to all such matters, and with respect to any matter within the scope of our authority, shall be conclusive and binding on the Enrollee and this Certificate. Any problem or Claims dispute between an Enrollee and us must go through our complaint and appeals process. If the problem or dispute is over a determination of Medical Necessity, classification of treatment as Experimental or Investigational or involves an Expedited Appeal, the appeal process is controlling.

7.1 Initial Communication and Resolution of a Problem or Dispute

We welcome and encourage (but do not require) discussion of any inquiry, complaint or dispute concerning interpretation of the provisions of this Certificate. Our Customer Service representative will make every effort to resolve the issue. If we are unable to resolve the issue to the satisfaction of the Enrollee, the Enrollee has the right to request a Level I Review.

1. **Definition:** A complaint is an expression of dissatisfaction about us. A complaint, however, is not and will ***not*** be considered to be or handled as an "appeal" as described in Section 9.3 below. An "appeal" must be initiated and conducted as described in Section 9.3 below.
2. **Oral Complaints:** An Enrollee having a complaint regarding anything about us may contact a Customer Service Department at 501-228-7111 or 1-800-235-7111 to assist in resolving the matter informally. The Enrollee may submit a written complaint if not satisfied with the resolution. An Enrollee is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints:** The Enrollee may submit a written complaint to us at the following address:
   QualChoice
   Attention: Appeals and Grievance Coordinator
   P. O. Box 25610
   Little Rock, Arkansas 72221-5610
4. **Complaint Resolution:** We will acknowledge receipt of a written complaint within 5 working days. We will investigate the complaint and send the Enrollee a response with resolution. If we are unable to resolve the written complaint within 30 calendar days due to circumstances beyond our control, we will provide notice of the reason for the delay before the 30th calendar day.

7.2 Types of Requests and Claims

1. **Pre-Service Claim:** A Pre-Service Claim is a request for a service that requires prior notification and approval of the benefit prior to receiving the service. These are services, for example, that are subject to pre-certification as set forth in the Pre-Authorization of Services section of this Certificate.
2. **Post-Service Claims:** Post-Service Claims are those claims for services that have already been received by the Enrollee.
3. **Urgent Care Claim:** An Urgent Care Claim is a request for a service that a physician with knowledge of the Enrollee's medical condition has determined that without the service the Enrollee's:
   A. Medical condition would subject the Enrollee to severe pain that cannot be adequately managed; or
   B. Life, health or ability to regain maximum function could be seriously jeopardized.
4. **Concurrent Care Claim**: A Concurrent Care Claim is a request for a service that arises when Medical Necessity of an on-going course of treatment to be provided over a period of time has been approved.
5. **Administrative Issues**: We consider issues such as those regarding eligibility, coverage, level of coverage, rescission of coverage (that is, cancellation or discontinuance of coverage

retroactively (unless due to lack of timely premium payment)), and adherence to prescribed procedures as Administrative Issues.

6. **Medical Issues**: We consider issues such as a determination of Medical Necessity, the definition of a medical treatment as Experimental or Investigational, or the sufficiency of clinical information to make a coverage determination, to be a Medical Issue.

7.3 Appeal Process

1. **Initiating a Pre-Service, Concurrent Care, or Post-Service Level I Appeal:** The Enrollee (or the Enrollee's healthcare provider with regard to a Pre-Service Claim, Concurrent Care Claim or Urgent Care Claim) has 180 calendar days from the date of receipt of the initial determination was made to file a formal written appeal, under this Section 9. To initiate an appeal, an Enrollee (or the Enrollee's healthcare provider) must write to our complaint and appeals coordinator at the following address:

   QualChoice
   Attention: Appeals and Grievance Coordinator
   P.O. Box 25610
   Little Rock, AR 72221-5610

2. **Appeal of Pre-Service Claim and Concurrent Care Claim**
   A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee, and respond as soon as possible, but not later than fifteen (15) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
   B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within fifteen (15) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
   C. **Initiating a Pre-Service or Concurrent Care Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing to our Complaint and Appeals Coordinator at the address listed in Subparagraph 1 above.
   D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee and/or the treating healthcare provider have the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within fifteen (15) calendar days of the Committee's hearing.
   E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within fifteen (15) calendar days from the receipt of the appeal.
   F. **Expedited Appeals**. A request for an expedited appeal for a Pre-Service Claim or Concurrent Care Claim will be treated as an appeal of an Urgent Care Claim as described in Section 9.3 below subject to the request meeting the criteria for an Urgent Care Claim.

3. **Appeal of Post-Service Claims**
    A. **Level I Appeal of Administrative Issues.** After receipt of the written appeal, the Level I Reviewer, will conduct an investigation of the appeal, including consulting if necessary with our Level I Appeals Committee and respond with a decision as soon as possible, but not later than thirty (30) calendar days from the receipt of the appeal. We will send the Enrollee a letter defining the decision of the appeals review. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
    B. **Level I Appeal of Medical Issues.** After receipt of the written appeal on a Medical Issue, the Appeals Coordinator will request from Enrollee's treating providers medical records and treatment plans. Consideration of the Enrollee's Level I Appeal cannot begin until we receive such records. When we receive the necessary records, we will assign the Level I Appeal to a medical director for review and we will notify the Enrollee of a decision within thirty (30) calendar days of receipt of adequate documentation of medical care and medical processes. If the decision is not in favor of the Enrollee, the letter will explain the reasons for the findings and will include the contract language and or policy supporting the decision.
    C. **Initiating a Post Service Level II Appeal:** Within thirty (30) calendar days of receiving a written adverse determination of a Level I Appeal, the Enrollee has the right to initiate a Level II Appeal by writing or facsimile to our Complaint and Appeals Coordinator at the address or fax number listed in Subparagraph 1 above.
    D. **Level II Appeal of Administrative Issues.** The Level II Appeal Committee meeting at our office will hear a Level II Appeal of an Administrative Issue. The Enrollee has the right to appear in person or attend via teleconference to supplement their written appeal and respond to the Level II Appeal Committee's questions. The Enrollee will be notified of the Level II Appeal Committee's decision within thirty (30) calendar days of the Committee's hearing.
    E. **Level II Appeal of Medical Issues**. A medical director different than the one that made the Level I Appeal decision will conduct the review of a Level II Appeal of a Medical Issue. That medical director will have all medical information on the case and any new information provided as part of the Level II Appeal. The Enrollee will be notified of the Level II Appeal decision within thirty (30) calendar days from the receipt of the appeal.
    F. **No Expedited Appeals**. There are no expedited appeals for Post-Service Claims.

4. **Appeal of Urgent Care Claim**
    A. **Initiating a Level I Appeal and Level II Appeal.** If the Enrollee requests an expedited review and a health care professional with knowledge of the Enrollee's medical condition certifies the determination as a general pre-service request that would seriously jeopardize the Enrollee's life or health or the Enrollee's ability to regain maximum function, the Enrollee or their health care professional may submit an appeal to the Appeals and Grievance Coordinator by facsimile to 501-228-9413. An expedited appeal may be submitted by telephone, 501-228-7111 or 1-800-235-7111 followed by a written confirmation.
    B. **Level I Appeal and Level II Appeal.** An appeal of an Urgent Care Claim will be handled by us as a Medical Issue. A medical director will make the determination on review at both levels of appeal in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Appeals Coordinator initially receives the request for review. A medical director different than the one that made the Level I Appeal decision will make the Level II Appeal decision.

7.4 Documentation

1. **Written Appeals:** All appeals must be submitted in writing and include the Enrollee's name, identification number, and reference to the specific appealed Claim. However, an appeal related to an Urgent Care Claim as defined in Section 9.2 above can initially be submitted

orally so we can immediately commence consideration. We require written confirmation of such Urgent Care Claim appeal even though investigation will have begun.

2. **Right to Information of Enrollee:** We shall provide the Enrollee, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information that:
    A. Were relied upon in making the benefit determination;
    B. Were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
    C. Demonstrate compliance with the terms of the Certificate; and
    D. Constitute a statement of policy or guidance with respect to the Certificate concerning the denied treatment option or benefit for the Enrollee's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In addition, we will provide the Enrollee, free of charge, with any new or additional rationale and/or evidence we consider, rely on, or is generated in connection with the appeal. We will provide this rationale and/or evidence as soon as possible and sufficiently in advance to allow the Enrollee a reasonable opportunity to respond prior to the date of a determination on the appeal being made by us.

3. **Right of Enrollee to Submit Information:** The Enrollee may submit with the request for an appeal any additional written comments, issues, documents, records and other information relating to the request or Claim. The Enrollee and the treating health care provider(s) are required to provide individual(s) reviewing the appeal, upon request, access to information necessary to determine the appeal. Such information should be provided not later than 5 days after the date on which the Appeals Reviewer's request for information is received, or, in the case of an Urgent Care Claim or Concurrent Care Claim, at such earlier time as may be necessary to comply with the applicable timelines. The Enrollee's failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but not providing the requested information may affect the Appeals Reviewer's determination. When adequate medical records for consideration of the appeal do not accompany the appeal of a Medical Issue, there are only two options: denial of the appeal or delay of the decision until we receive the records. We will inform the Enrollee of the process of obtaining the medical records, an effort in which the Enrollee may assist. At any point, the Enrollee may insist we make a determination based on the records then available, in which case we will render the decision within thirty (30) days.

7.5 Conduct of Appeals

An appeal is conducted following the procedures below:

1. **Scope of Review**: The Appeals Reviewer(s) shall conduct a complete review of all information relating to the request or Claim and shall not afford deference to the initial determination or previous appeal review in conducting the review.
2. **Qualifications of Appeals Reviewer**: The Appeals Reviewer is an individual or committee of individuals selected by QualChoice with appropriate expertise and who did not deny the request or Claim that is the subject of the appeal.
3. **Review of Medical Judgment**: When reviewing a request or Claim in which the determination was based in whole or in part on medical judgment, including determination with regard to whether a particular treatment is experimental, investigational, or not Medically Necessary or appropriate, we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual consulted in the initial determination, nor the subordinate of such individual. Upon request of the Enrollee, the identity of the health care professional(s) consulted in conducting the review who are our employees will be provided, without regard to whether we relied upon the advice of the health care professional in making the benefit determination.

7.6 Legal Actions

Prior to initiating legal action, the Enrollee must complete the appeal process in accordance with this section. No one may bring legal action after the expiration of 3 years from the required submission time of the request or Claim.

7.7 Authorized Representative

1. **One Authorized Representative:** An Enrollee may have one representative and only one representative at a time, to assist in making a complaint, submitting a request or Claim, or appealing an unfavorable determination.
2. **Authority of Authorized Representative:** An Authorized Representative shall have the authority to represent the Enrollee in all matters in connection with the Enrollee's complaint, request, Claim or appeal of a determination. If the Enrollee has an Authorized Representative, references to the terms "The Enrollee" or "Enrollee" in this document refer to the Authorized Representative.
3. **Designation of Authorized Representative:** One of the following persons may act as an Enrollee's Authorized Representative:
    A. An individual designated by the Enrollee in writing in a form approved by us;
    B. The treating provider, if it is a Pre-Service Claim, a Concurrent Care Claim, or an Urgent Care Claim, or if the Enrollee has designated the provider in writing in a form approved by us (Note: An assignment of benefits to a provider will not constitute appointment of that provider as an authorized representative);
    C. A person holding the Enrollee's durable power of attorney;
    D. If the Enrollee is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Enrollee by a court of competent jurisdiction; or
    E. If the Enrollee is a minor, the Enrollee's parent or legal guardian, unless we are notified the Enrollee's request or Claim involves health care services where the consent of the Enrollee's parent or legal guardian is or was not required by law and the Enrollee shall represent himself or herself.
4. **Term of the Authorized Representative:** The authority of an Authorized Representative shall continue for the period specified in the Enrollee's appointment of the Authorized Representative or until the Enrollee is legally competent to represent him or herself and notifies us in writing the Authorized Representative is no longer required or authorized.
5. **Communication with Authorized Representative:** If the Authorized Representative represents the Enrollee because the Authorized Representative is the Enrollee's parent or legal guardian or attorney in fact under a durable power of attorney, we shall send all correspondence, notices and benefit determinations to the Authorized Representative.

    If the Authorized Representative represents the Enrollee in connection with the submission of a Pre-Service Claim or Concurrent Care Claim, including a Claim involving Urgent Care, or in connection with an appeal, we shall send all correspondence, notices and benefit determinations to the Authorized Representative. If the Authorized Representative represents the Enrollee in connection with a Post-Service Claim, we will send all correspondence, notices, and benefit determinations in connection with the Enrollee's Claim to the Enrollee, but we will provide copies of such correspondence to the Authorized Representative upon request. The Enrollee understands it will take us a reasonable period, approximately 30 days, to notify all its personnel about the termination of the Enrollee's Authorized Representative and we may communicate information about the Enrollee to the Authorized Representative during the notification period.

7.8 External Medical Review

After you have exhausted your Level I and Level II appeal rights with QualChoice and QualChoice has made its final determination with regard to your appeal, a voluntary external review process may be available to you. To find out more about this external review process, including an external expedited review in the event of an Urgent Care Claim, please contact QualChoice's Appeal Coordinator at 501-228-7111 or 1-800-235-7111.

The external review process is only available if the determination you appealed was based on whether the healthcare service was Medically Necessary or experimental/investigational and the adverse determination by QualChoice will cause you to have medical expenses in excess of $500.00.

An external review is not available for such things as a denial based on an express exclusion in the Certificate, an express limitation in the Certificate, dollar limits under the Certificate, fraud or misrepresentation, or failure to follow procedures in obtaining healthcare provider access.

Your request for an external medical review must be made within sixty (60) days of your receipt of QualChoice's denial and in writing to:

Appeals and Grievance Coordinator
QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

The written communication must be marked and identified as a "*Request for External Review*".

The medical review would be conducted by an independent, external medical review organization selected by QualChoice from a list of approved organizations maintained by the Arkansas Department of Insurance. You would be required to pay a $25.00 fee to file the request for the external review which would be refunded to you in the event QualChoice's determination is reversed by the independent medical review organization.

As part of the external review process, you have the opportunity to submit additional information to QualChoice related to your Claim for consideration by the external review organization for consideration. You will be required to authorize the release of any medical records necessary for the external review organization to reach a decision.

The determination by the external review organization is binding and final on both you and QualChoice, unless other remedies are available under applicable state or federal law.

You may contact the Arkansas Insurance Commissioner for assistance at any time. The mailing address is: Arkansas Insurance Department, Attn: External Review Assistance, 1200 West Third Street, Little Rock, AR 72201. Their telephone number is 501-371-2640 or toll free 800-852-5494. Their email address is insurance.consumers@arkansas.gov.

8. SUBROGATION

If you have an injury or illness caused by a third party, we will provide Covered Services for such injury or illness. Acceptance of such Covered Services constitutes consent to the provisions of this section. This is a prerequisite to recovery by us against any third party for the cost of Covered Services. Our recovery rights under this Section 10 extend to worker's compensation and uninsured and underinsured motorist coverage.

You agree to protect our lien rights if you have an injury or illness caused by a third party. You may be due money from a third party for the cost of Covered Services. If so, our liability for your Benefits will be subrogated to any such recoveries. We have the right to sue any third party in your name, as permitted by applicable state law. If you receive payment from a third party or any other insurer for the cost of Covered Services, you are obligated to reimburse us. You may reduce such reimbursement by our pro rata share of reasonable attorney's fees and costs you incurred in obtaining such recovery.

You agree to cooperate fully to facilitate enforcement of our rights under this Section 10. This may include executing, delivering and filing further documents and instruments. You also agree to furnish such information and assistance as we may reasonably require to fully enforcing the terms of this Section 10.

You agree to take no action prejudicing our rights and interests under this Section 10.

9. PRE-EXISTING CONDITIONS

No Benefits for services of any kind are provided under this Certificate for treatment of a Pre-existing Condition (as defined in the Section 11) for a period of 12 months from an Enrollee's effective date of coverage under the prior employer group policy. This 12-month period is referred to as the "pre-existing period". If the Enrollee submitted an application for coverage during their initial Waiting Period under the prior employer group policy, the pre-existing period begins on the first day of the Waiting Period. If the Enrollee did not apply for coverage within the Waiting Period, the pre-existing period begins on the Enrollee's original effective date under the prior employer group policy.

9.1 Periods of Creditable Coverage

Periods of Creditable Coverage (as defined in applicable law and regulations) will reduce the Pre-existing Condition exclusion period. For purposes of this Certificate, Creditable Coverage includes the coverage an Enrollee had under the prior employer group policy. The notification an Enrollee receives from us sets out the Enrollee's Pre-existing Condition period as calculated by us. In reaching this determination, we consider Certificates of Creditable Coverage provided by the Enrollee's prior health plans and health insurers as well as information otherwise available to us.

Failure to cooperate fully shall constitute grounds for affirming any original Pre-existing Condition exclusion period determination, and denying Claims on that basis.

9.2 Applicability of Pre-existing Exclusion

This Pre-existing Condition exclusion is not applicable to:

1. Pregnancy if you or your enrolled spouse is pregnant as of the effective date of this Certificate; or
2. An Enrollee under the age of 19.

9.3 Request for Reconsideration of Pre-existing Condition Limitation Period Determination

How to request a reconsideration of a Pre-existing Condition Limitation Period Determination:

1. If an Enrollee disagrees with the Pre-existing Condition limitation period calculated by us, the Enrollee can ask for a reconsideration of this determination by sending a written request to:

   Enrollment Department
   QualChoice
   P.O. Box 25610,
   Little Rock, AR 72221-5610

2. An Enrollee's request for reconsideration must include a written statement of the correct period of time the Enrollee had Creditable Coverage and relevant evidence to corroborate the Enrollee's statement. Relevant evidence can include Certificate(s) of Creditable Coverage issued by prior health plans, explanation of benefits, claims or other correspondence from a health plan indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a benefit certificate, or the telephone number of the Member's prior heath plan.
3. By requesting reconsideration of the determination of a Pre-existing Condition limitation period, the Enrollee agrees to cooperate with efforts to verify prior coverage. Cooperation includes, but is not limited to, providing written authorization to request a certificate on the Enrollee's behalf from prior health plan(s) and insurer(s), providing information about the Enrollee's prior health plan(s) and insurer(s), such as telephone numbers and addresses, and assisting the efforts to determine the validity of the corroborating relevant evidence.
4. We will make our final determination of an Enrollee's Pre-existing Condition limitation period within a reasonable period of time after it receives the Enrollee's written request for reconsideration.
5. Appeals from a denial of a Claim based on the Pre-existing Condition exclusion (as distinguished from appeals concerning the calculation of the Pre-existing Condition limitation period) should follow the general appeal procedures outlined in Section 9.

10. GENERAL PROVISIONS

10.1 Amendment

QualChoice reserves the right to change the benefits, conditions and premiums covered under this Certificate. If we do so, we will give thirty (30) days written notice to you and the change will go into effect on the date fixed in the notice.

10.2 Assignment

You cannot assign any Benefits or monies due under this Certificate to any person, corporation, organization or other entity. Any assignment by you will be void and have no effect. Assignment means the transfer of your right to the Benefits provided under this Certificate.

10.3 Notice

Any notice we give to an Enrollee will be in writing. It will be mailed to him or her at the home address as it appears in our records. Notice to us must be in writing and mailed to our offices at:

QualChoice
P.O. Box 25610
Little Rock, AR 72221-5610

10.4 Your Medical Records

We may need to obtain copies of your medical records from any of your treating providers. This may be necessary to properly administer your Benefits. You, or your legal representative, agree to sign an appropriate authorization for release of medical records upon our request. If you elect not to consent to the release of medical records, we may be unable to properly administer your coverage. If this occurs, we have the right to deny payment for impacted Covered Services.

10.5 Request for Certificate of Creditable Coverage

You may request from us at any time a Certificate of Creditable Coverage by contacting our Customer Service Department.

10.6 Notice of Claim

We must receive your Claim for Benefits within no more than 12 months from the date you receive the service. Failure to meet this requirement will result in payment denial.

10.7 Who Receives Payment Under This Certificate

We will make payments under this Certificate directly to the Network Providers providing care.

10.8 Recovery of Overpayments

On occasion, an incorrect payment may be made to you. Reasons for this may include when you are not eligible, the service is not covered, or Coordination of Benefits was omitted. When this happens, we will explain the problem to you in writing. You must return to us within 60 days the amount of the mistaken payment. Alternatively, you must provide us with written notice stating the reasons why you may be entitled to such payment. In accordance with applicable law, we may reduce future payments to you in order to recover any mistaken payment. We will recover overpayments and mistaken payments made to providers directly from them.

10.9 Confidentiality

Medical records and other information concerning your care we receive from providers are confidential. We will use such information only to administer your coverage. We will only disclose such information as required to coordinate Benefits or assure continuity of care. Other disclosures require your written consent. See your Notice of Privacy Practices for a more detailed description of your privacy rights and duties.

10.10 Complaint and Appeals
You are entitled to have any complaints heard by us. We are obligated to hear and resolve such complaints, including complaints against Network Providers, in an equitable fashion. The rules and procedures for complaints and appeals set forth in Section 9 will be followed.

10.11 Right to Develop Policies and Guidelines
We reserve the right to develop or adopt policies and guidelines for the administration of Benefits under this Certificate. These policies and guidelines will be interpretive only and will not be contrary to any terms of this Certificate. If you have a question about the policies or guidelines used to apply to a particular Benefit, you may contact us or visit our website at www.qualchoice.com for further information.

10.12 Limitation on Benefit of This Certificate
No person or entity other than our Enrollees and us shall be entitled to bring any action to enforce any provision of this Certificate. The covenants, undertakings, and agreements set forth in this Certificate shall be solely for the benefit of our Enrollees and us.

10.13 Applicable Law
This Certificate, the rights and obligations of our employees and us under this Certificate, and any claims or disputes relating thereto, shall be governed by and construed in accordance with Federal and Arkansas law.

10.14 Headings
Section and subsection headings contained in this Certificate are inserted for convenience of reference only. They shall not be deemed to be part of this Certificate for any purpose. They shall not in any way define or affect the meaning, construction or scope of any of the provisions hereof.

10.15 Pronouns
All pronouns and any variations thereof shall be deemed to refer to the masculine, feminine, neuter, singular or plural, as the identity of the person or entity may require.

10.16 Severability
If any part of any provision of this Certificate or any document or writing given pursuant to or in connection with this Certificate shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity or unenforceability only. Such invalidity or unenforceability will in no way affect the remaining parts of such provision or the remaining provisions of this Certificate.

10.17 Waiver
The waiver by us or any Enrollee hereunder of a breach of or a default under any of the provisions of this Certificate shall not be construed as a waiver of any subsequent breach or default of a similar nature. The failure of any of such parties, on one or more occasions, to enforce any of the provisions of this Certificate or to exercise any right or privilege hereunder, shall not be a waiver of any of such provisions, rights or privileges hereunder.

11. DEFINITIONS
There are other definitions, usually capitalized, contained in various sections throughout this Certificate. The capitalized words or terms used in this Certificate and are not otherwise defined have the meanings set forth below:

11.1 **"Accidental Injury"** means a bodily injury (other than intentionally self-inflicted injury) happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and which is the direct cause of the loss, independent

of disease or bodily infirmity. Accidental Injury to teeth does not include any damage caused by chewing or biting any object.

11.2 **"Benefits"** means reimbursement or payments for health care available to Enrollees covered under this Certificate.

11.3 **"Benefits Summary"** means a document containing specific information relating to your coverage and Cost Sharing Amounts under this Certificate. The information may include amounts for Deductibles, Co-payments, Coinsurance, Out-of-Pocket Limits and lifetime maximum benefits as well as visit and day maximums for limited services.

11.4 **"Calendar Year"** means the period of one year beginning January 1 and ending on December 31 as identified in your Benefits Summary.

11.5 **"Certificate"** means this conversion medical benefits policy through which Benefits are provided, in whole or in part, as reflected in this Certificate.

11.6. **"Certificate Holder"** means you, the person to whom this Certificate is issued.

11.7 **"Child"** means the Certificate Holder's natural child, legally adopted child, child for whom the Certificate Holder is the legal guardian, or stepchild. "Child" also includes a child for whom the Certificate Holder is the adoptive parent during the Waiting Period prior to completing the adoption. Foster children are not included in the definition of "Child".

11.8 **"Claim for Benefits" or "Claim"** means (i) a request for payment or prior approval (when required under the Certificate) for a service, supply, medication, equipment or treatment covered by the Certificate, (ii) that is submitted to us by an Enrollee, a healthcare provider with an assignment of benefits from the Enrollee, or an Enrollee's authorized representative, and (iii) is submitted consistent with QualChoice's standard claim filing policies and procedures (copies of which are available on request).

11.9 **"Coinsurance"** means a fixed percentage of the Maximum Allowable Charge you must pay toward the cost of certain Covered Services. Those Covered Services subject to the application of Coinsurance are identified in your Benefits Summary. Coinsurance is subject to an annual maximum limit.

11.10 **"Complication of Pregnancy"** means a condition requiring facility confinement, when the pregnancy is not terminated, the diagnosis of which is unrelated to the pregnancy but causes the mother's health to be adversely affected. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity which threaten the mother's health or life.

The following will also be considered a Complication of Pregnancy:

1. A c-section occurring after failure of a trial of labor;
2. An emergency c-section required because of fetal or maternal distress during labor;
3. An ectopic pregnancy which is terminated;
4. A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and
5. A non-scheduled c-section.

11.11 **"Co-payment"** means a fixed dollar amount you must pay each time you receive a particular Covered Service to which a Co-payment applies.

11.12 **"Cost Sharing Amount"** means an amount you are required to pay each time you receive a particular service to which Deductibles, Co-payments, Coinsurance or benefit limitations apply. These requirements are set forth in your Benefits Summary.

11.13 **"Covered Dependent"** means any member of the Certificate Holder's family who meets the eligibility requirements of Section 5, who is enrolled in the Certificate, and for whom we have received premium.

11.14 **"Covered Service(s)"** means services or supplies for which Benefits are available (i.e., payments may be made) as described in this Certificate. Covered Services do not include services or supplies and care excluded pursuant to Section 4 or which do not meet the definition of "Medically Necessary" in this section and the other qualifications set forth in Section 3.

11.15 **"Custodial Care"** means provision of routine care that is primarily for meeting personal needs, including assistance with activities of daily living.

11.16 **"Deductible"** means a certain fixed dollar amount you must incur before we begin to pay for the cost of Covered Services provided to you during each Calendar Year. Each Enrollee must satisfy the Deductible before we begin to pay for Covered Services to which the Deductible applies.

11.17 **"Emergency"** means those health care services provided on a 24 hour/365 days a year basis to evaluate and treat medical conditions of a recent onset and severity, leading a prudent lay person, possessing an average knowledge of medicine and health, to believe his or her condition, sickness, or injury is of such a nature where failure to seek immediate medical care could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

11.18 **"Enrollee"** means a Certificate Holder and any spouse of a Certificate Holder or dependents of the Certificate Holder or of the Certificate Holder's spouse covered under this Certificate.

11.19 **"Enrollment Application"** means the form to be accurately completed by prospective Certificate Holders when they apply for enrollment.

11.20 **"High Dose Chemotherapy"** means Chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., granulocyte, colony-stimulating factor, granulocyte-macrophage colony-stimulating factor, reinfusion of stem cells, reinfusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any Enrollee who received this High Dose Chemotherapy, to prevent life threatening complications of the chemotherapy on the Enrollee's own blood cells.

11.21 **"Injectible Prescription Medications"** means any injectible pharmaceutical that has been approved by the Food and Drug Administration.

11.22 **"Maximum Allowable Charge"** means the schedule of fees established by us for payments to providers for Covered Services and which may be less than actual charges billed by Network Providers or Out-of-Network Providers. **Please Note:** All Benefits under this Certificate are subject to and shall be paid only by reference to the Maximum Allowable Charge as determined at the discretion of QualChoice. This means that regardless of how much your health care provider may bill for a given service, the Benefits under this Certificate will be limited by the Maximum Allowable Charge we establish. If you use a QualChoice Network Provider and QualChoice is the primary payor, that provider is obligated to accept our established rate as the Maximum Allowable Charge, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, **if you use an Out-of-Network Provider you will be responsible for all amounts billed**.

11.23 **"Medical Advisory Committee"** means an internal committee composed of practicing physicians selected by QualChoice from the Arkansas medical community.

11.24 **"Medical Policy" or "Medical Policies"** means a statement developed by QualChoice that sets forth the medical criteria for coverage under QualChoice's benefit certificate or insurance policy. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are or are based on nationally accepted guidelines and peer reviewed medical literature. Our Medical Advisory Committee reviews and approves all internally developed Medical Policies. Medical Policies are available from QualChoice, at no cost, upon request, or the Medical Policies can be reviewed on QualChoice's web site at www.qualchoice.com.

11.25 **"Medically Necessary" or "Medical Necessity"** means a Covered Service, which in the opinion of our medical personnel:

A. Provides for the diagnosis or treatment of the Enrollee's covered medical condition;
B. Is consistent with and necessary for the diagnosis, treatment or avoidance of the Enrollee's illness, injury or medical condition in relation to any overall medical/health conditions;
C. Meets the standards of good and generally accepted medical practice, as reflected by scientific and peer reviewed medical literature, for the specific and overall illness, injuries and medical conditions present;
D. Is not primarily for the convenience of the Enrollee, his or her family, his or her physician, or other provider; and
E. Is effective, the safest, and the most cost-efficient level of service or supply appropriate for the Enrollee's illness, injury or medical/health condition(s).

11.26 **"Mental Health or Substance Use Disorder"** means any psychiatric disorder or disorder of emotion or thought, appropriately classified as an Axis I diagnosis in accordance with the current edition of the Diagnosis & Statistical Manual of Mental Diseases of the American Psychiatric Association (DSM) classification.

11.27 **"Network Facility"** means a hospital facility or other facility (e.g., hospice, ambulatory surgery center, etc.) that has entered into an agreement with us to make Covered Services available to Enrollees.

11.28 **"Network Primary Care Physician"** means a physician who has entered into an agreement with us regarding, among other things, willingness to provide primary care Covered Services to Enrollees and who may be utilized by an Enrollee as his or her primary care physician. The following will be considered to be a primary care physician: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

11.29 **"Network Provider"** means a Network Primary Care Physician, Network Specialist, Network Facility or other provider having an agreement with us to make Covered Services available to Enrollees.

11.30 **"Network Specialist"** means a medical or surgical specialist who has entered into an agreement with us regarding, among other things, willingness to provide specialty Covered Services to Enrollees and who may be utilized by an Enrollee as his or her specialty physician. The following will not be considered to be a specialist: (a) Pediatricians, (b) Family or general practice physician, (c) Internal medicine physician, and (d) Geriatric physician.

11.31 **"Out-of-Network Provider"** means a physician, facility or other provider that has not entered into an agreement with us to make Covered Services available to Enrollees. Regardless of any other provision in this Certificate, the extent of QualChoice's coverage for services provided by an Out-of-Network Provider is as set forth in your Benefits Summary.

11.32 **"Out-of-Pocket Limit"** means the maximum amount you pay every Calendar Year as set out in your Benefits Summary.

11.33 **"Pre-existing Condition"** means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on (1) the Member's effective date with the Certificate or (2) the first day of their Waiting Period, as applicable. The period is calculated by counting back from the first day of the Waiting Period, rather than from the Member's actual effective date. If the Member does not apply within the Waiting Period, the 6-month period is calculated by counting back from the Member's effective date of coverage.

Notwithstanding the definition above, with respect ONLY to an Enrollee who is under nineteen (19) years of age, "Pre-existing Condition" means a condition that was present before the effective date of coverage, or if coverage is denied, the date of the denial, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition can be identified through information relating to health status before the Enrollee's effective date of coverage or if coverage is denied, the date of the denial, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the Enrollee, or review of medical records relating to the pre-enrollment period.

11.34 **"Referral"** means a specific written approval from us that an Enrollee seeks for additional evaluation or treatment from an Out-of-Network Provider. A general statement by a Network Provider stating a patient should seek a particular type of service or provider does not constitute a Referral under this Certificate. We issue Referrals for a specific period as determined by us. It is your responsibility to ensure all services provided to you are completed during the appropriate period. There will be no coverage for services rendered outside the approved period.

11.35 **"Service Area"** means the geographical area in which we are licensed by the State of Arkansas to conduct business.

11.36 **"Waiting Period"** means the period from your date of hire until the date you were first eligible for coverage under your employer group policy.

Michael E. Stock, President & CEO

QCA Health Plan, Inc.

The QualChoice Building

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